S.H.I.N.E. GLOBAL MODEL FOR SECOND EPISCOPAL DISTRICT MOBILIZATION FOR HIV/AIDS PREVENTION AND CARE USING GOVERNMENT AND FAITH-BASED INITIATIVES

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A FINAL DOCUMENT SUBMITTED TO
THE DOCTORAL STUDIES COMMITTEE
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF DOCTOR OF MINISTRY

UNITED THEOLOGICAL SEMINARY
TROTWOOD, OHIO
DECEMBER, 2007

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ABSTRACT

S.H.I.N.E. GLOBAL MODEL FOR SECOND EPISCOPAL DISTRICT MOBILIZATION FOR HIV/AIDS PREVENTION AND CARE USING GOVERNMENT AND FAITH-BASED INITIATIVES

by

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The Spiritual Growth and Maturity, Health and Wholeness, Insight, Networking and Empowerment (SHINE) Global Model addresses HIV/AIDS prevention and care needs of persons in the mid-Atlantic region, United States of America. Clergy and lay leaders mobilized in the 2nd Episcopal District, African Methodist Episcopal (AME) Church encompassing Maryland, District of Columbia, Virginia, and North Carolina. A mixed methodology was employed resulting in 471 surveys and 9 in-depth interviews. Outcomes: Increased understanding of awareness levels, collaboration with government and private agencies, and interventions such as DVDs and Action Packet production, and 38 outreach and trainings with 5,155 constituent contacts.

ACKNOWLEDGEMENTS

Over the years, there have been numerous persons who have supported this doctoral work in varied ways. I am deeply moved and humbled to think of all who walked with me during any or all phases of the journey to complete requirements. This was evident in the prayers offered, technical assistance provided and guidance given by personal confidantes and professional mentors. As stated in Philippians 4:3-5 (King James Version), "I thank my God upon every remembrance of you, always in every prayer of mine for you all making request with joy, for your fellowship in the gospel from the first day until now…"

Only God truly knows how much I am grateful and how the support strengthened not only my academic accomplishments, but also enhanced my spiritual growth and maturity. While care was given to extend ongoing thanks and gratitude, I pause here to lift up some persons and organizations, even as these and others may have been mentioned later in this document.

To my family, I salute and revere you with all my heart, especially the matriarch, my beloved centenarian grandmother, Mrs. FeDora Britt McGee at whose bedside I completed the final document for submission and defense. Without Grandma's years of nurture and Christian witness, I would not have come this far in life and still have hope for the future. Her love, prayers and our most cherished times of singing praises to God will live with me forever! My parents, the Rev. David J. Sparrow and Mrs. Gladys Sparrow, experienced achieving the Doctor of Ministry degree with me. The document,

degree and related fruits certainly are conceivable only with you at my side enjoying them all. To my brother, David Keith Sparrow, I love you and thanks for being appropriately tough and savvy. To my nephew, David Keith Sparrow, II ("Keithie'), thank you for your help with data entry. To both Keithie and my niece, LaCheyna Sparrow, I pray that my efforts inspire you and that God will grant you all your desire to attain educationally and in life for God's glory.

Special thanks are extended to my Uncle James McGee and Aunt/"Grandma" Leola Sparrow Keene for being steadfast in your belief in me as a faithful carrier of the Sparrow-Blackstone and McGee-Britt heritage. A most precious place in the chronicles of my life is reserved for my adopted grandparents, Dr. Henry H. Mitchell and Dr. Ella Pearson Mitchell, whose books inspired me, and since the weeks before my initial sermon, prayerfully shared their wise counsel and tireless support.

My mentor at United Theological Seminary, Dr. Michael O. Thomas, as well as his wife Dr. Debyii Thomas, consistently encouraged and compelled me to keep pressing on in light of opportunities and despite challenges encountered. Thank you tremendously!

I am most grateful for the integrity and expertise shared by professional associates including: Dr. Randy Rowel of Morgan State University School of Community Health and Policy and RR and Associates, a long-time colleague and a most reliable evaluator who assisted with the qualitative data; Dr. Veronica Clarke-Tasker of the Howard University College of Pharmacy, Nursing and Allied Health Sciences, for support with certain aspects of quantitative data collection and analysis (and even the sometimes humorous discoveries at non-traditional hours); and Dr. Peter Winch, my former helping me retain views of the big picture. In addition, Dr. Charles Moore and Dr. Robert Negero

of Howard University inspired and facilitated further statistical analysis and presentation of data. Dr. William B. Greenough, III of the Johns Hopkins University School of Medicine and Bloomberg School of Public Health taught me much about clinical research and is my key role model for operating with excellence and compassion while making worldwide contributions to the quality of life of patients and their families.

Partial support for this doctoral research came as a result of my serving as program director for grants with the United States Department of Health and Human Services, Office of Minority Health (Cooperative Agreement Number: US2MP03002). Former project managers who competently worked with me in health and wholeness initiatives related to faith-based HIV/AIDS awareness include: the Rev. Vanessa Alexander-Tisdale, Sister Donette Branch, the late Rev. Karen Young and the Rev. Thann Young. I am appreciative to other colleagues and members of the board of directors at the following places of employment: the former Congress of National Black Churches; Pilgrim Community Outreach Corporation; Richard Allen Community Development Corporation; Second District Religious, Educational and Charitable Development Projects, Inc.; and the Heartland Home Health Care and Hospice.

There are many sisters in ministry who gave unselfishly of their time and uniquely blessed me in countless ways: the Reverends Deborah Bell-Shepard, (Dr.) Priscilla I. Boswell, Vanetta L. Brice, Anita J. Gould, Karen Harrison, Andra Hoxie, (Dr.) Mary Chris Newton, (Dr.) Lucille Norville-Perez, Annette Roane; and Sisters Vanesia Monroe and N. Cajetta Stephens. In addition, I treasure the more than two decades of sisterly love of LaVeda Bacetti, Donna Campbell, Michele Gay Crosby and Karen Nicolini. Appreciation for encouraging words and support also goes to the Reverends

(Dr.) Mankekolo Mahlango-Ngcobo, (Dr.) Glenda Hodges, and Darlene James, as well as Sister Cornelia Burkhalter.

I give thanks to the following ministers who assisted in the technical aspects of the project (especially taping and DVD production), the Reverends Dana Swann, Keith E. Andrews, II, Maria Mallory White and all those who aided them.

I am most grateful to the fabulous faculty and sensational staff and consultants at United Theological Seminary especially the following persons: previous directors/deans of the Doctoral Study Program that I interacted with at critical points, Dr. Clinton D. McNair, Dr. Larry Welborn and Dr. Josephine Whitely-Fields; Ms. Janice Kronour who always provided the essential link and information for the doctoral process; Ted Baxendale for his early morning writing seminars and professional editing skills; Edna Ebersole, Tonya Cummings, Martha Anderson and those supporting their offices; and other administrators, former President G. Edwin Zeiders and President Wendy J. Deichmann Edwards.

My Episcopal leaders in the Second Episcopal District, African Methodist Episcopal (AME) Church deserve the utmost respect for their role in fostering awareness in congregations and communities in the mid-Atlantic region, and especially for support of my efforts: Retired Bishop Vinton R. Anderson and Supervisor Vivienne Anderson and current presiding prelate, Bishop Adam Richardson, Jr., and Supervisor Connie Speights Richardson. Sister Jackie Dupont-Walker, former Executive Aide, was instrumental in helping the project get out of the blocks. Project success was due to the strong participation and candid survey and interview responses by laity and clergy members (context associates) of the Second Episcopal District. I applaud Dr. Cellestine

Cheeks and members of the Second Episcopal District Lay Organization for their strides made in HIV/AIDS prevention that were apparent through participation and commitment to this project.

A special thank you to pastors (in addition to my father) who in some instances chaired the non-profit organizations affiliated with this project including the Rev. Christine Moore and the Rev. Dr. Lois A. Poag-Ray, and the Rev. Jonathan L. Weaver. I also thank God for the fellowship and prayers of the officers and members of local congregations where I served during the course of doctoral training: Lee Memorial AME Church in Kensington, MD, Pilgrim AME Church in Washington, DC and Faith AME Church in Laurel, MD. Likewise, I fondly remember those at the sites of my early religious experience, Mount Zion AME Church in Knoxville, MD, Davis Memorial AME Church in Baltimore, MD and First Baptist Church in Franklin, Virginia.

A number of other AME leaders have inspired me to think and serve globally. Warmest thanks are given to the late Bishop Robert Thomas, Mother Beverly Thomas, Daniel and Revival Smith, the Josias family and AME members of the Fifteenth Episcopal District who helped facilitate my stay in Namibia and South Africa. Other Episcopal leaders who served in the Eighteenth Episcopal District, Southern Africa, were influential in their words and actions to promote healthy lives and this project: Bishop William P. Deveaux, Supervisor Dr. PAM Deveaux, Bishop Vashti M. McKenzie, Supervisor Stan McKenzie. Retired Bishop Philip R. Cousin and Supervisor Dr. M. Joan Cousin are commended for their trailblazing work throughout the world to raise HIV/AIDS awareness and care, and for motivating me. Certainly, praiseworthy are the retired Bishop John Hurst Adams and Supervisor Dr. Dolly D. Adams who since my high

school years never failed to encourage and foster my educational pursuits and professional growth.

Finally, I express heartfelt gratitude to all those not mentioned above who have personally entrusted me with friendship and care of any sort leading to the completion of the doctoral program.

To God Be The Glory For The Great Things God Has Done!

PREFACE

The connection between ministry, medicine and public health has been a long-time area of interest to the author. Each discipline is in its own right worthy of in-depth study and reflection. However, it is the intersection of the three disciplines that leads to a new level of understanding of God's glory and compassion for humanity. As the issue of Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) is considered, the importance of a multi-disciplinary approach becomes apparent. What happens when expressions of compassion originating from one's love of God and others are girded by the best in medical knowledge and research as well as public health practice? Who is served? How are people's needs met? What is the impact of caring on the one that extents aid? What are the responsibilities of institutions? What can a denomination do to respond to the health crisis? What community health insights from Southern Africa, Taiwan and China may be applied? These questions inspired the doctoral work for the global model entitled "SHINE: Spiritual Growth and Maturity, Health and Wholeness, Insight, Networking and Empowerment."

Individual and collective action of leaders within the Second Episcopal District of the African Methodist Episcopal Church mobilized churches to address HIV/AIDS. A wholistic, Episcopal district-wide approach describes the direct and indirect impact.

The Rev. Cassandra A. Sparrow

September 2007

DEDICATIONS

To my centenarian grandmother, Mrs. FeDora McGee,

My parents, the Reverend David and Mrs. Gladys Sparrow,

My Brother, D. Keith Sparrow and

The Entire Sparrow-Blackstone-McGee-Britt Family,

As well as

To the legacies of the late Reverend Karen L. Young, Program Manager for the majority of ministry project, and the late Bishop Robert Thomas who was always inspirational,

And Finally,

To all persons infected and affected by the HIV/AIDS pandemic

who will prayerfully benefit from the work of

Eye on the Sparrow International, LLC.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AME	African Methodist Episcopal
CDC	Centers for Disease Control and Prevention
HIV	Human Immunodeficiency Virus
KJV	King James Version
NIV	New International Version
PCOC	Pilgrim Community Outreach Corporation
SPSS	Statistical Package for the Social Sciences
CCP/PCS	Center for Communication Programs/Population Communication Services
Second District RED	Second District Religious, Educational and Development Projects, Inc.

You are the light of the world. A city on a hill cannot be hidden. Neither do people light a lamp and put it under a bowl. Instead they put it on its stand, and it gives light to everyone in the house. In the same way, **let your light so shine** before men, that they may see your good deeds and praise your Father in heaven.

—Matthew 5:14-16, NIV

INTRODUCTION

This document consists of a global model for faith-based health interventions. While there are many lessons learned and insights from years of work with church-initiated and church-operated health and wholeness projects, this document cannot adequately convey the details. This Doctor of Ministry (DMin) project provides an earnest attempt to capture effective strategies for the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) awareness interventions from a Christian denomination, the African Methodist Episcopal (AME) Church. HIV/AIDS is a term used to collectively refer to three categories of diagnoses: 1) a diagnosis of HIV infection (not AIDS), 2) a diagnosis of HIV infection and a later diagnosis of AIDS, and 3) concurrent diagnosis of HIV infection and AIDS.[1] The primary modes of HIV transmission for African Americans include sexual contact and injection drug use.[2]

For an effective health promotion intervention, the entire life and not just physical aspects must be explored. HIV/AIDS prevention efforts must not just focus on a discussion of prevention methods (e.g., abstinence, use of contraceptives such as condoms, monogamous relationships, and behavioral changes to alleviate

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[1] Centers for Disease Control and Prevention. *CDC HIV/AIDS Fact Sheet: HIV/AIDS among African Americans* (Atlanta, GA: United States Department of Health and Human Services, Centers for Disease Control and Prevention, January 2007), 6.

[2] Ibid., 2. Other modes of transmission in African Americans account for 1% in females and 2% males. These modes include mother-to-child and blood transfusions. Worldwide sexual contact is the most common mode of HIV transmission with other modes occurring in varying degrees.

risky behavior). Rather, what is needed is a wholistic approach to healthy living that increases a person's self-worth, encourages spiritual growth and maturity, strengthens personal relationships and facilitates a supportive environment.

Leaders within the church are in a unique position to positively impact the lives of those in the congregation and in the neighborhoods surrounding the church. This document presupposes that mobilization efforts are enhanced as a greater understanding of constituents' interest and participation in health events and HIV/AIDS awareness levels are obtained. The ministry researcher seeks to demonstrate that the independent variable, Annual Conference affiliation, will influence the methodologies used to obtain HIV/AIDS education. For example, important dependent variables include: the extent that members of the AME Church have participated in overall health and HIV/AIDS presentations/workshops at various levels of the denomination's infrastructure, as well as HIV prevention and related care actions that are developed and supported by members of the denomination. Partnerships with other faith-based, private organizations and public agencies play an important role in the outreach and inreach efforts of the AME Church. An overview of the chapters for this project is provided in the section that follows.

The first three chapters comprise Part I – Framework for Action. In Chapter One, "Ministry Focus," the author's focus on ministry, medicine and public health are described in light of the spiritual pilgrimage with domestic and international insights. The spiritual pilgrimage and ministry context are synthesized through a ministry model that both mobilizes persons to increase HIV/AIDS awareness and begins addressing overall well-being concerns.

The ministry research project model is entitled the "**S**piritual Growth and Maturity, **H**ealth and Wholeness, **I**nsight, **N**etworking and **E**mpowerment (SHINE) Global Model for Second Episcopal District Mobilization for HIV/AIDS Prevention and Care Using Government and Faith-based Initiatives." This is a four-phased model: 1) mobilization, 2) implementation, 3) evaluation and sustainability and 4) replication and expansion. Only the first phase is addressed in this project, since collection of baseline data and the issuance of a call to action constituted the primary foci.

Chapter Two, "Church Health Programs: State of the Art of This Ministry Model," examines public health and religious literature on overall health and more specifically, HIV/AIDS. Government and faith-based initiatives are explored. This chapter also includes nine models previously specified by the ministry researcher as suitable frameworks for proposed faith-based health interventions. The first presented is entitled "TIME Model" which was developed by the ministry researcher to assist in implementation of health interventions with collaborations between government and faith-based institutions. TIME stands for **T**rust, **I**n-person contact, **M**ode of entry and **Existing** church organizations and ministries. The eight other models include: 1) annual and periodic church events, 2) community and academic support, 3) advocacy, 4) church coalition/ministerial alliance, 5) integrated ministry, 6) cluster, 7) health and wholeness committee and 8) specialized training/continuing education.

Chapter Three, "Theoretical Foundation for Action," includes the biblical, historical, theological and ethical bases for the ministry model. The biblical content primarily addresses scriptural passages related to paradigms on how God calls people to carryout God's Mission (Exodus 3, 4:29-31 and Matthew 4:12-25) and God's care for

people (Luke 12:1-7 and Matthew 10:28-31). The historical section presents an overview of the early Christian church's view and response to epidemics, as well as AME Church health-related practices and policies (e.g., eighteenth century involvement by Bishop Richard Allen, founder, and others assisting of persons impacted by the yellow fever epidemic). "Hurdler Theology" is introduced to provide a framework for overcoming obstacles such as those faced by infected and affected persons. The ethical foundation for action (from Christian and Afro-centric perspectives) concludes the chapter.

Part II consists of the SHINE Global Model applied in the Second Episcopal District. "The Methodology" is discussed in Chapter Four. Three research questions and three hypotheses are given. With action research methodology as a basis, a mixed method approach was employed using both qualitative and quantitative research. Data was primarily collected in the Second Episcopal District (which includes Maryland, District of Columbia, Virginia, North Carolina) at various intervals during the period 2003-2004. The overview of the SHINE Global Model, interventions, research design, measurements and instrumentation are all covered in the fourth chapter.

Chapter Five describes the results of "Field Experience" in the Second Episcopal District. Activities conducted in the jurisdiction are presented including the following components: collection of data including a chronology of key activities; analysis of data; and outcomes presented according to the three research questions, as well as by overall mobilization efforts.

Chapter Six, "Summary, Reflections and Conclusion," contains: 1) a summary of qualitative and quantitative results and 2) reflections on the project including lessons learned and recommendations for capacity-building, further implementation of the

SHINE Global Model – Phase I (Mobilization) and areas for expanded research. Combined, the above items provide a tested framework for an international, faith-based HIV/AIDS prevention and care mobilization model. A glossary and the appendix are also provided.

CHAPTER ONE

MINISTRY FOCUS

Area of Ministry

This document presents an approach to addressing the HIV/AIDS pandemic by an Episcopal District of the African Methodist Episcopal (AME) Church. The worldwide spread of HIV/AIDS threatens the health and overall well being of congregants and community residents. The model for ministry described in this document mobilizes clergy and lay leadership to further develop and sustain HIV/AIDS inreach and outreach efforts throughout the Second Episcopal District.[1] The Second Episcopal District encompasses the mid-Atlantic region of the United States including Maryland, Virginia, North Carolina and the District of Columbia.

Events that shaped the ministry researcher's interest in creating effective church-based health ministries, and specifically in the area of HIV/AIDS, are covered in this chapter. These inspirational events or areas of study are covered in several sections: 1) Spiritual Pilgrimage in the United States of America, Taiwan and Southern Africa; 2) Education and Professional Experience Related to Addressing HIV/AIDS and Related Health Concerns; 3) Understanding the Context for Ministry – The Second Episcopal District, AME Church; and 4) Development of the Spiritual Growth and Maturity, Health and Wholeness, Insight, Networking, and Empowerment (SHINE) Global Model for

[1] For the purposes of this project, "inreach" is a term that refers to activities conducted within the church structure that is designed to specifically meet the needs of those who are members or who attend or regularly worship at an AME Church. All other efforts are considered outreach.

Second Episcopal District Mobilization for HIV/AIDS Prevention and Care Efforts Using Government and Faith-based Initiatives. Beginning in the Second Episcopal District, the SHINE Global Model is designed to minister to the needs of persons infected and affected by HIV/AIDS. It provides the ministry focus and key strategies to mobilize churches to reach underserved populations worldwide. The SHINE Model is the culmination of the ministry researcher's journey to integrate the areas of interest in medicine, ministry/missions and public health. This chapter captures the historical timelines and contextual analysis that fostered this process.

Spiritual Pilgrimage: United States of America, Taiwan, and Southern Africa

United States of America: Early Religious Experience and Exposure to Health Concerns

Child and adolescent years in a clergy family had a tremendous impact on this researcher's life. Raised in the State of Maryland as a preacher and missionary's daughter, experiences in the church and society were preparation to think critically while the desire to help others became more intense. In middle school, questions emerged in this researcher's mind about why so many testimonies heard in church declared, "The doctors gave me up, but Jesus healed my body."[2] This provoked an ongoing struggle to understand how any physician would give up on a patient, and why the statement of such seemed to support a stronger faith statement of God's healing and deliverance. As the researcher's interest in medicine was developing simultaneously with her search for spiritual understanding, God established a passion for service in an arena that would combine medicine, ministry/missions and public health.

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[2] This sentiment was echoed in many testimonies in churches, and as the ministry researcher recalls, including those attended at the time in the Baltimore, Maryland area.

Observing one's family in action strengthened the commitment to do the best for God, and to consider giving no less than all to make a positive difference in the lives of others. Parents, a maternal grandmother and other relatives were most influential in this ministry researcher's development as they shared faith and encouraged this author's spiritual growth and pursuit of a career in the health or medical field. Four areas created a foundation for this researcher's commitment to life-long service to the church and community, and thus, gave the underlying inspiration for this ministry project: 1) seeing how persons functioned in various church leadership roles, 2) increasing understanding of the organization, structure and function of the AME Church, 3) valuing ecumenical activities, and 4) generating an appreciation for civic involvement and community action.

First, seeing parents in various leadership roles gave insight to the work required to foster individual and collective good. Within the AME Church, father served as a pastor (in ministry for over fifty years) and mother was an area and local President of the Women's Missionary Society. However unknowingly, the ministry researcher's future was being shaped by the experiences with her parents. Examples of events that had a substantial impact on this researcher's life include: going on visits to serve Holy Communion to persons who were sick and shut-in, sitting in area Women's Missionary Society meetings and learning of various community service projects, joining father at a local rescue mission for homeless men as he delivered sermons, seeing the family's response to midnight calls following deaths and accidents, as well as observing, and assisting where feasible, in the day-to-day responsibilities of serving several congregations in small towns, urban and suburban locations. In addition, the joys and pains of the Christian life were witnessed first-hand including watching baptisms,

observing couples getting married in our home and at the church, and seeing the grief as well as celebration of life at funerals. Witnessing her parents and grandmother's daily prayers, scripture reading and regular involvement in church life made this researcher realize the spiritual discipline required for effective service. This inspired her spiritual discipline.

Second, the organization, structure and function of the AME denomination became clearer as various conferences were observed from the balcony or rear seats of various churches, beholding the interpersonal dynamics and so-called politics in the operations of the institutional church. The true potential of the church to change lives was evident at a young age, even though the process for action within the church hierarchy was at times bewildering. Interestingly, this ministry researcher received much encouragement by church leaders, which in turn, led to greater involvement in youth activities as well as in health ministries. The ministry researcher has served the AME church at several levels to address health concerns.[3]

Ecumenical and civic activities added to the ministry researcher's desire to engage in service to the church and community. Third, participation in ecumenical activities helped broaden the ministry researcher's perspective on how collaboration with those of other denominations and faith traditions can broaden one's understanding and strengthen efforts for increased issue awareness and positive change. Ministerial alliance meetings, joint worship services (e.g., Thanksgiving, Christmas, Easter, and Martin

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[3] The ministry researcher was one of the founders of a local church health ministry and has served in leadership capacities to address health concerns through work with many AME churches. Examples of the latter include service as: co-chair of a Committee on Health Education for the Capitol District, chair for the Ecology, Temperance and Health Committee in the Washington Annual Conference and liaison for denominational Living Well initiatives with the Connectional Health Commission. See a later section in this chapter on "Educational and Professional Experiences" for more information.

Luther King Commemoration Day) and combined Vacation Bible School provided examples of forums for such learning.

Fourth, an appreciation for civic involvement was gained after accompanying her parents to voting booths, as well as on various occasions seeing pain and suspicion as a result of the work of hate and supremacist groups. The benefits of community unity to address concerns were seen through information dissemination, town hall meetings, and some initiatives of churches and other religious and community-based organizations, educational institutions and government agencies.

This ministry researcher experienced a sense of joy and fulfillment in both observing and serving people in the United States with diverse needs regardless of race and socio-economic status. The early childhood exposures sparked later adolescent and adult action. Confirmation was received to expand this outlook on needs in the United States of America to other populations as the ministry researcher studied Chinese language and culture while fulfilling pre-medical requirements.

Republic of Taiwan: The Calling and Recognition of a Global God

In the summer of 1988, this ministry researcher took an initial trip abroad where, as first understood, the call to medical missions was realized. Participation in a foreign study program in Taiwan sponsored by the University of Massachusetts, Amherst, fostered the spiritual growth and appreciation for global concerns. Building upon prior study of the Chinese (Mandarin) language at Dartmouth College in Hanover, New Hampshire, it was fascinating to learn Chinese in a context that would allow communication with people on everything from faith to socio-political issues.

A better understanding of the Taiwanese culture was obtained as this ministry researcher traveled throughout the island. Worship experiences as well as spiritual reflections made connections between the health and belief systems (particularly religious beliefs) more evident. The ministry researcher experienced a new boldness in faith while entering local churches, participating in church services and sharing with unbelievers. Traditional Chinese medicine and herbal treatments were intriguing as were the current and historical governmental initiatives to combat disease and environmental concerns in both Taiwan and mainland China.

Regardless of the feasibility of methodologies used on a moral or ethical basis, there was something to be said for collective action to address issues of societal concern such as health promotion and disease prevention. Furthermore, divine inspiration was received while in dialogue with a medical missionary on sabbatical from service in South Africa, as well as when more information was received on medical missions ships. The above occurrences in addition to intense Bible reading and reflection led this ministry researcher into a spiritual awareness of a calling to be involved in the healing of diseases and spreading the Gospel throughout the world. Four years later, while preparing for a trip to Southern Africa, this call was better understood as a call to ministry along the path of ordination.

Southern Africa: Exploring and Participating in the Work of the AME Church

Fifteenth and Nineteenth Episcopal Districts, AME Church: Namibia and South Africa

In September 1990, God provided the means for the ministry researcher to fulfill a dream to go to Southern Africa where God's compassion was seen displayed on those with various health concerns. The trip was also an opportunity to further clarify aspects of the ministry researcher's calling while serving in the Fifteenth and Nineteenth Episcopal Districts. The Fifteenth Episcopal District encompassed Namibia as well as the western portion of South Africa (particularly, the Cape Province). The Nineteenth Episcopal District includes eastern South Africa[4] (including the Natal Province where the ministry researcher spent the most time). The three-month internship was supported by the John Sloane Dickey Endowment (affiliated with Dartmouth College), the Chestnut Grove Presbyterian Church in Baltimore County, Maryland, the AME Church and others.[5] The internship was arranged in conjunction with the AME-Service and Development Agency, an international non-profit organization affiliated with the AME Church.

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[4] The ministry researcher spent two months of her 1990 journey in Windhoek, and other parts of Namibia and the Western Cape of South Africa – both territories comprised the Fifteenth Episcopal District at that time. Angola was later added to this Episcopal District's jurisdiction. In addition, one month of service occurred in the Nineteenth Episcopal District, specifically in the Natal Province and in the city of Johannesburg. In 1990, the late Bishop Robert Thomas presided over the Fifteenth Episcopal District with Mother Beverly Thomas as Episcopal Supervisor. The late Bishop Harold B. Senatle presided over the Nineteenth Episcopal District. The researcher stayed in the homes of AME families in both countries: in Namibia, with new high government officials who returned from exile, and in South Africa, with a South African physician who was also an AME preacher's daughter.

[5] The AME Church's support came from: 1) the Service and Development Agency under the leadership of the former Chairman, the late Bishop Donald Ming and former Executive Director, the Reverend Jonathan L. Weaver, as well as 2) the Women's Missionary Society led by the former Connectional President, Mrs. Delores Kennedy Williams. The Chestnut Grove Presbyterian Church support was facilitated by its Missions Department.

The internship facilitated many lessons learned through observation of faith in action in the medical environment. The destruction of apartheid was witnessed firsthand as was the work needed to reconcile and heal the people. While volunteering in a church-owned Namibian clinic, antibiotic supplies decreased while patient lines grew longer.[6] At the Hlasbisa Hospital in South Africa, it was further realized how important it is to maintain the comfort and dignity of patients, despite limited resources such as equipment failure, unequal distribution of physicians, poor water supply and sanitation, and overcrowded wards and the growing spread of HIV/AIDS. Inspiration was received while observing pregnant women engage in morning and evening devotionals on the wards. Many of these women arrived at the hospital one month before their delivery dates, and slept on the floor in order to ensure they were in place to have a safe delivery and to receive proper care. The various experiences in Namibia and South Africa helped affirm that ministry and medicine were a part of the ministry researcher's calling. Further collaboration with persons from Southern Africa in the coming years sustained the ministry researcher's passion for service in underserved communities worldwide.

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[6] For many Namibians, the People's Primary Care Clinic of Komasdal located in a renovated church in the capital area of Windhoek was considered a trusted facility that was owned and operated by a division of the Council of Churches on Namibia (CCN). On any given day as many as 100 patients were seen. Mainly nurses staffed the clinic, along with two physicians. The ministry researcher served primarily in the clinic's medicine dispensary (pharmacy). She was given her first-time opportunity to see a surgery performed at a local hospital, and also witnessed the unequal resources in facilities due to the impact of the apartheid system (i.e., the official policy of racial segregation in the Republic of South Africa and its former territory of Namibia).

Eighteenth Episcopal District, AME Church:
Botswana, Lesotho, Swaziland and Mozambique

The Eighteenth Episcopal District consists of five Annual Conferences within four countries: Lesotho, Swaziland, Botswana, Mozambique and Northeast Lesotho.[7] In 1998, while serving as the director of the Health and Wholeness Program of the former Congress of National Black Churches, Inc. (CNBC), the ministry researcher helped plan an international conference in Botswana. This three-day conference in March 1999 was sponsored by the Eighteenth Episcopal District in collaboration with CNBC.[8] There were approximately 300 participants in this conference that was titled, "The Faith Community Addresses Health and Wholeness: Beginning with HIV/AIDS."[9] There were three focal groups that prepared action plans: 1) pastors and other clergy, 2) youth and the community, and 3) the Women's Missionary Society and other non-governmental agencies (NGOs). The ministry researcher served as a technical advisor to the youth and community group. The action plan guides and conference evaluations were developed by

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[7] African Methodist Episcopal Church, *The Doctrine and Discipline of the African Methodist Episcopal Church 2004* (Nashville, TN: AMEC Publishing Company, 2005), 234.

[8] During the conference period, Bishop William P. DeVeaux presided and Dr. PAM DeVeaux served as the Episcopal Supervisor over the Eighteenth Episcopal District. The ministry researcher's further work with CNBC to address HIV/AIDS is described in a later section in this chapter, "Professional Experiences."

[9] The ministry researcher was also present for the dedication of the site for the Joan Cousin Women's Empowerment Centre in Lobatse, Botswana. At that time, Dr. Joan Cousin served as the Episcopal Supervisor for the First Episcopal District which sponsored the project largely through support of its local Women's Missionary Societies in churches in Delaware, Pennsylvania, New York, New Jersey and the New England states. The Centre focuses on HIV/AIDS education services.

the ministry researcher and approved by the Episcopal Supervisor of the Women's Missionary Society.

As in the Fifteenth and Nineteenth Episcopal Districts, the ministry researcher's experiences in the Eighteenth Episcopal District prompted periods of reflection and recommitment to ministerial and health pursuits. Overall, the spiritual pilgrimage in the United States of America, Taiwan and Southern Africa exposed the researcher to the physical, emotional, economic and other needs due to the HIV/AIDS crisis. Further communication with church leaders from countries, as well as additional academic and technical training reinforced the ministry researcher's interest in HIV/AIDS.[10] This ultimately led to the name and design of this doctoral ministry project.[11]

Educational and Professional Experiences Related to Addressing HIV/AIDS and Associated Health Concerns

Much of what was described above in the spiritual pilgrimage occurred simultaneously with academic training at both undergraduate and graduate levels. Likewise, concurrent professional experience also reinforced the ministry researcher's sense of calling and commitment to health-related ministries. Both academic training and professional experiences related to HIV/AIDS are described in this section.

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[10] Example of follow-up communication on AME Church HIV/AIDS awareness efforts with the leadership during their tenure in various Episcopal Districts include: Bishop Vinton R. Anderson (Second), Bishop Adam J. Richardson, Jr. (Nineteenth and Second), Bishop Gregory G. M. Ingram (Fifteenth) and Bishop Vashti Murphy McKenzie (Eighteenth). Bishop Richardson and Episcopal Supervisor Connie Richardson currently serve the Second Episcopal District, the ministry context, and provided the researcher with guidance and approval for this project.

[11] As described in a later section of this chapter, the name of this project model, "SHINE" emerged as a result of experiences in Southern Africa, particularly in Botswana.

Educational Experiences

An undergraduate "Women in Africa" course at Dartmouth College exposed the ministry researcher to issues on the spread of HIV among female prostitutes in Central Africa due to their involvement with travelers. Furthermore, participation in the Harvard Health Professions Program at Harvard Summer School opened the researcher's eyes to the following issues through program components: sexual identity and health care concerns raised in a reproductive anatomy seminar; the role of religion and health in a medical anthropology course; scientific advances in a cell biology course; and a preceptorship with a physician at Cambridge Hospital in Massachusetts. The preceptorship allowed observation of medical care for mainly Haitian patients who were HIV positive and/or were undergoing treatment for tuberculosis. This introduced the researcher to the physical, emotional, societal and religious concerns that arise after HIV diagnosis. More specifically, the approach the physician used to address the pain of one patient was life-changing as the patient was reassured of the priest's understanding and this patient's priest would not condemn her. The physician's prior communication with this clergyman enabled the patient to be comforted.

In 1992, the ministry researcher engaged in further HIV/AIDS training while completing a Master of Health Science degree at the Johns Hopkins University School of Hygiene and Public Health in Baltimore, Maryland. In particular, an "Epidemiology of AIDS" course and other studies in international health led to a greater understanding of care needs in underserved populations worldwide. For example, a project in a qualitative

research methodologies course gave the researcher firsthand awareness of risk factors among homeless men who were cocaine users and/or already HIV positive.[12]

For two years, work as an intern with the Asia Division of the Johns Hopkins University Center for Communication Programs/Population Communication Services (CCP/PCS) provided initial exposure to "Enter-educate" programs. These programs consisted of creative use of mass media and entertainment to primarily address issues of maternal and child health, family planning and reproductive health. Furthermore, as a part of the Baltimore City Healthy Start's Community Evaluation Team (under the direction of Dr. Patricia O'Campo, a faculty member of the formerly named Maternal and Child Health Department of Johns Hopkins), the ministry researcher learned more about the role of environment as a factor in facilitating or hindering people's health. Mapping of churches, interviews, and outreach efforts to the faith community in East and West Baltimore enabled the connection between newer health programs and existing institutions.

Professional Experiences

In addition to the work experiences in selected educational settings noted in the above section, other professional experiences helped shape the ministry researcher's love for and commitment to faith-based health initiatives. For more than seven years this ministry researcher worked as the director of the Health and Wholeness Program,

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[12] A thesis was completed on church-based outreach and health initiatives such as reducing infant mortality by Baltimore City Healthy Start and a proposed model for increasing maternal health in the Fifteenth Episcopal District of the AME Church. In addition, experiences that also helped shape the ministry researcher's interest in the global impact of issues such as HIV/AIDS include: a course on maternal health care in developing countries that revealed emergent care, maternal mortality and reproductive and sexual health issues. Overall, "at risk" populations were better understood through completion of the master's degree requirements.

formerly the National Health Program, for the Congress of National Black Churches, Inc. While with this organization, an increased understanding of the following issues were obtained through the planning, implementation and evaluation of HIV/AIDS and related health projects: substance abuse issues; HIV/AIDS awareness methods across eight historically Black denominations; issues related to youth HIV prevention; and other faith-based HIV/AIDS prevention and care initiatives among African-Americans. It was in this context that the ministry researcher developed church-based health models and met numerous religious and health leaders who combined their faith with medical, public health and nursing expertise to effectively assist others.[13] The importance of incorporating spiritual and faith dimensions into health care infrastructure planning was reinforced while serving at times as the only faith community representative in certain governmental work groups and programs.

Professional experiences related to HIV/AIDS prevention and treatment efforts of AME churches and their affiliated non-profit organizations (as well as other collaborating agencies) have been the ministry researcher's focus over the past four years. Work as the director of Health and Wholeness Ministries for the Pilgrim Community Outreach Corporation (PCOC) in Washington DC, led to the implementation of two federally-funded HIV/AIDS projects within congregations in the District of Columbia, Maryland, Virginia, North Carolina and New York. The Office of Minority Health (OMH) supported these projects which were transferred from CNBC to PCOC. The ministry researcher gave oversight to the work of the two OMH projects as the program director with both organizations. One project, "Pilgrim Community Outreach HIV/AIDS Series for Member Denomination" helped fund portions of research presented in this document.

[13] See Chapter Two for examples of church-based health models.

Ongoing opportunities to share HIV/AIDS awareness were also granted through the Committee on Health Education of the Capitol District of the Washington Annual Conference, AME Church.

As the ministry researcher's company, Eye on the Sparrow International, LLC, was founded, further insights on the needs of persons infected and affected by HIV/AIDS were gained as the Executive Director of two agencies: 1) the North Carolina non-profit Second District Religious, Educational and Charitable Development Projects, Inc. (Second District RED, Inc.) which serves congregations and communities in the Second Episcopal District, AME Church, and 2) the Richard Allen Community Development Corporation that provides primary medical care, case management and transportation services to HIV positive persons in Prince George's County, Maryland, and raises HIV/AIDS awareness through an annual Pan African Festival and HIV/AIDS Prayer Breakfast with officials from African Embassies.[14] Assistance provided to the AME Church's Connectional Health Commission has enabled understanding of health efforts across the denomination based on the quadrennial "Living Well" theme set forth by the Council of Bishops. Lastly, the experiences serving as a hospice chaplain to patients with AIDS and their families has also increased awareness of end of life issues.

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[14] The Pilgrim Community Outreach Corporation is affiliated with Pilgrim AME Church in Washington, DC and Richard Allen Community Development Corporation is affiliated with Greater Mount Nebo AME Church in Bowie, Maryland. Second District RED, Inc. is headquartered in Washington DC and serves constituents in the Second Episcopal District including Maryland, North Carolina, Virginia, and Washington DC. During the course of this project, the researcher worked with these three organizations, as well as CNBC mentioned earlier.

Understanding the Context for Ministry: Second Episcopal District, AME Church, the Mid-Atlantic Region of the United States of America

The Second Episcopal District is comprised of five Annual Conferences including: Baltimore, Washington, Virginia, North Carolina and Western North Carolina.[15] The ministry researcher is an ordained itinerant elder in the Washington Annual Conference, consisting of the District of Columbia and surrounding areas. The context for ministry, the Second Episcopal District, is described in two sections: 1) Second Episcopal District Background and 2) Statistical Overview.

Second Episcopal District Background

The Second Episcopal District is an historic district in the African Methodist Episcopal Church. Just as discrimination prompted Richard Allen and others to leave St. George's Methodist Episcopal Church in Philadelphia, persons of Negro descent in Baltimore likewise sought a new fellowship. The following appears in the historical statement in the AME Book of Discipline which traces its history to November 1787:

> About this time, the colored people at Baltimore and other places were treated in a similar manner as those in Philadelphia, and they were compelled to seek places of worship for themselves, rather than go to the law. This induced the people to call a General Conference in April, 1816, to form a Connection. Delegates appointed to represent different churches met those of Philadelphia and taking into consideration their grievances, and in order to

[15] African Methodist Episcopal Church, *The Doctrine and Discipline*, 234.

> secure their privilege and promote union among themselves, it was:
> Resolved, "That the people of Philadelphia, Baltimore and all other places who should unite with them, should become one body under the name and style of the African Methodist Church." [16]

One account records that in 1818, the Baltimore Annual Conference opened with 10 members including Philadelphia District representatives.[17] In 2007, Baltimore Annual Conference, with its 30,526 members, opened at historic Bethel AME Church in Baltimore, Maryland in its 191st Session.[18] In terms of early AME Church history, only Mother Bethel AME Church in Philadelphia has such a prominent role as Bethel in Baltimore.

Since 1816, there have been thirty-two terms served by Bishops in the territory now called the Second Episcopal District, beginning with Bishop Richard Allen, the first AME Bishop, and continuing with the current presiding prelate, Bishop Adam Jefferson Richardson, Jr. The AME General Conference decided to establish Episcopal Districts Church in 1852.[19]

Today, there are approximately 367 churches in the Second Episcopal District including stations and missions. The Second Episcopal District has its headquarters in the

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[16] Daniel A. Payne, *History of the African Methodist Episcopal Church* (Nashville, TN: AMEC Sunday School Union, 1998), 3, 13. In a historical book first printed in 1891 by the sixth Bishop of the AME Church, it is acknowledged that there was debate about whether the denomination started through efforts in Philadelphia or Baltimore.

[17] Ibid., 19.

[18] Baltimore Annual Conference data taken from the Second Episcopal District Planning Meeting 2007 Workbook and Agenda.

[19] Adam J. Richardson, Jr. and Connie Speights Richardson, *Second Episcopal District African Methodist Episcopal Church 2007 Schedule of Annual Conferences, Agenda, Worship and Program Guide* (Washington DC: AME, 2007), 10-11.

nation's capitol, Washington, District of Columbia. The Second Episcopal District theme given by Bishop Richardson is, "Exalting Christ, Expanding His Church, Enabling His People." The denomination's quadrennial theme from June 2005 through May 2009 includes yearly focal areas of "Living Well, Serving Well, Managing Well and Ending Well."

In light of the Second Episcopal District's pioneering history in the AME Church, it seems fitting that it would initiate a program to continue its legacy of justice and service to those who feel disenfranchised. The Episcopal district-wide HIV/AIDS awareness mobilization effort proposed in this project is in keeping with Jesus' reading of Isaiah 61:1-2 (KJV), "The Spirit of the Lord is upon me, because he hath anointed me to preach the gospel to the poor; he hath sent me to heal the brokenhearted, to preach deliverance to the captives, and recovering of sight to the blind, to set at liberty them that are bruised, To preach the acceptable year of the Lord."[20]

In 1998, leaders from the Second Episcopal District formed a separate non-profit entity incorporated in the State of North Carolina. This organization is the Second District RED, Inc. This HIV/AIDS ministry research project was conducted in the context of Second Episcopal District which is served by Second District RED, Inc. As noted in the previous section entitled "Professional Experiences," the Second District RED, Inc. worked on HIV/AIDS awareness in collaboration with PCOC, a non-profit agency affiliated with a Pilgrim AME Church in Washington DC where the ministry researcher served as the director of health and wholeness ministries.

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[20] Luke 4:18-19 KJV

Statistical Overview

This section covers demographic information on: 1) the population at the start of this project (2003) and current estimates, as well as 2) HIV/AIDS morbidity and mortality data for the territory in the Second Episcopal District, along with discussion of risk factors.

Demographics

Table A.1 provides an overview of the population trends in the three states and the District of Columbia that also comprise the jurisdiction of the Second Episcopal District (See Appendix A, "Demographics," for additional information related to this section). Data is taken from two, ten-year census periods (1990 and 2000) as well as 2006 estimates. The 2006 estimates reveal that a total of 22,696,646 people live in the region. It is also interesting to note that there was a population increase in all states, but an overall decline in population in the District of Columbia (when comparing 1990 to 2006). Although the various reasons for this decline are not the primary focal points of this project, it is important to note that within the Second Episcopal District, as later discussion clarifies, the District of Columbia has the largest percentage of African Americans and also has the highest HIV/AIDS morbidity and mortality (See Appendix A, Table A.2 – The District of Columbia is 60.0% African American. See Appendix B, Tables B.2 for African American AIDS cases and Table B.3 for survival rates). Since the AME Church is historically Black/African American, it is essential to obtain a better understanding of the population and socioeconomic status of this segment of society. As Table A.2 suggests, the most recent 2000 Census data reveals the following percentages

of African Americans alone in the total population of a given state/district in the region of the Second Episcopal District: Maryland - 27.9%, District of Columbia - 60.0%, Virginia - 19.6% and North Carolina – 21.6%. Overall, in 2000 there were 4,948,561 African Americans, accounting for 23.6% of the total regional population (20,996,373). African Americans represented 203,537 or 47.5 % of the families in the region below the poverty line, and 925,349 or 42.8% of the individuals below the poverty line.

Table A.3 (also in Appendix A) provides social characteristics of African Americans in the region of the Second Episcopal District (compared to the overall population data) such as population age 25 years and over, educational levels attained and marital status. Data pertaining to educational levels indicate that 19.6% of the total African Americans in the region of the Second Episcopal District are high school graduates or higher, while 12.6% have a bachelor's degree or higher. For both of these classifications, Virginia has the lowest percentage, and the District of Columbia has the highest percentages of persons with a high school and bachelor's degree and higher. Public health trends in general show a proportionate relationship between educational level and health status.[21]

Other data in Table A.3 have implications for HIV/AIDS education messages in the Second Episcopal District. Overall, 21.5% of the population in the region of the Second Episcopal District is African American and age twenty-five and over. In 2000,

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[21] Joint United Nations Programme on HIV/AIDS (UNAIDS), *Report on the Global HIV/AIDS Epidemic, June 2000* (Geneva, Switzerland: UNAIDS, 2000), 42. The educational factors discussed include correlations such as "better educated people generally have greater access to information than the illiterate or uneducated, are more likely to make well-informed decisions and act on that information . . . have better jobs and greater access to money and other resources which can help them support healthier lives."

UNAIDS, *June 2006 Report on the Global HIV/AIDS Epidemic* (Geneva, Switzerland: UNAIDS, 2006), 15. This report states that data from Uganda indicates that "a child who drops out of school is three times more likely to be HIV positive in his or her twenties than a child who completes basic education."

there were 16.4% of population who were African American, married males and 15.1% were African American, married females.[22] Therefore, single adults comprise the majority of African Americans in the target area.

When the AME membership is considered (Table A.4, Appendix A), 114,689 members are in Second Episcopal District as of June 2007. The Washington Annual Conference which includes portion of Maryland, Northern Virginia and the District of Columbia has the largest membership, followed by (in descending order of total membership) the Baltimore, Western North Carolina, Virginia and North Carolina Annual Conferences.

Table A.5 in Appendix A displays the breakdown of locations of the 368 churches in the Second Episcopal District. The largest number of churches is in the North Carolina Annual Conference, and the smallest number is in the Baltimore Annual Conference.

HIV/AIDS Morbidity and Mortality

Data collection in this project started in the fall of 2003. This section primarily contains data published at the start of project, with some recent data for comparison purposes (See Appendix B, "HIV/AIDS Statistics," for additional information related to this section). Morbidity data is inclusive of extent or presence of an illness/disease in a given population, where as mortality refers to death rates. Morbidity and mortality data are covered with emphasis on three areas: 1) the global picture, 2) United States of America inclusive of among African Americans and persons in Second Episcopal District jurisdictions; and 3) special issues.

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[22] Both married categories excluded persons who were separated.

The Global Picture

A June 2000 report on the global HIV/AIDS epidemic revealed the following alarming statistics, as of data estimates collected by the end of 1999: [23]

- 34.3 million adults and children living with HIV/AIDS with a range of uncertainty of 25.8 million (low estimate) to 41.8 million (high estimate).
- 1.3 million children (ages 0-14) were living with HIV/AIDS, and 15.7 million were women (ages 15-49). In all these categories, the majority of cases were in sub-Saharan Africa.
- 13.2 million orphans worldwide with 12.1 million in sub-Saharan Africa. Some of the orphans in these totals are no longer alive or no longer under age 15.[24]
- 2.8 million AIDS deaths (adults and children), 1999.

Global rates continue to escalate. The most recent data through the end of 2005, and reported in 2006, indicated that there were an estimated 38.6 million people worldwide who were living with HIV (range 33.4 million - 46 million), an estimated 4.1 became newly infected with HIV (range 3.4 million - 6.2 million), and 2.8 million (range 2.4 million – 3.3 million) lost their lives to AIDS.[25]

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[23] UNAIDS, *June 2000 Report*, 124-125.

[24] Ibid., 120.

[25] UNAIDS, *2006 Report on the Global AIDS Epidemic: Executive Summary/UNAIDS* (Geneva, Switzerland: UNAIDS, 2006), 6.

A variety of factors have been listed as causes of people's vulnerability to HIV and AIDS.[26] Examples include:

1) Fear, stigma and denial
2) Uninformed and hence vulnerable – deficits in basic knowledge about transmission and prevention of HIV infection
3) Lack of education – people with more education tend to lead healthier lives, have greater access to information than those who are illiterate or uneducated, and are far more likely to protect themselves by using condoms for casual sex [27]
4) Men and women on the margins – such as illegal immigrants, drug users, sex workers or men who have sex with men
5) Young girls – more likely than boys to be uninformed about HIV, more likely to be coerced or raped, or a combination of factors such as "sugar daddies," older men who offer gifts or money for school fees in exchange for sex
6) Violence against women – domestic violence which reduces women's control over their exposure to HIV and places women in a poor position to question their husbands' extramarital

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[26] UNAIDS, *June 2000 Report*, 37-54.

[27] UNAIDS, *June 2000 Report*, 42-3. In contrast, the report also stated that "better jobs and more money can also mean more resources to buy alcohol, drugs and sex, and to move into urban areas where there are more jobs, but there are also high infection rates." Furthermore, some risky behaviors were shown to increase, such as "better educated individuals were generally more likely to have casual partners."

In addition, the report indicated in a study of mainly 15-19 year-olds in seventeen African and four Latin American countries that boys in some countries with secondary education were more likely than their primary school counterparts to have been sexually experienced by age eighteen. In comparison, better educated girls were more like to start having sex later. "(T)he proportion of girls sexually experienced by age 18 was 24% lower among those with secondary education than among those who had only been to primary school."

affairs, negotiate condom use or refuse to have sex, also sexual abuse of women and children, with long-term consequences of lowered self-esteem and those who find it harder to assert themselves in sexual negotiation in later life

The risk factors that make populations vulnerable worldwide, also hold true when domestic statistics in the United States of America are examined. However, some modes of transmission or risk factors are more common than others.

For African Americans, the following risk factors and barriers to prevention were listed by the Centers for Disease Control and Prevention: [28]

- Sexual risk factors – sex is the most likely cause of HIV infection in both African American males and females, women may not be aware of their male partners' risk factors such as unprotected sex with multiple partners, bisexuality, or injection drug use, and at the end of 2005 for African American men, primary risk factors included 48% for male-to-male sexual contact and 22% for high-risk heterosexual contact
- Substance use – the second leading cause of HIV infection for African American males and females
- Lack of awareness of HIV serostatus
- Sexually transmitted diseases (STDs) – 2005 reports stated that African Americans were about 18 times as likely as whites to have gonorrhea and 5 times as likely to have syphilis, genital

[28] Centers for Disease Control and Prevention, *CDC HIV/AIDS Fact Sheet: HIV/AIDS among African Americans* (Atlanta, GA: CDC, January 2007), 3-4.

lesions from some STDs can increase HIV infection 3- to 5 fold

- Homophobia and concealment of homosexual behavior – prompting some African American men who have sex with men (MSMs) to identify themselves as heterosexual or not to disclose their sexual orientation [29]
- Socioeconomic issues – such as in 1999, 1 in 4 African Americans were living in poverty [30]

Further statistical information on HIV/AIDS among African Americans is found in the next section.

United States of America

African Americans constitute the majority of persons in identified as being HIV infected (i.e., HIV seropositive (HIV+)) and are also disproportionately represented as having AIDS. Data below support this.

HIV Infection Cases

While representing approximately 13% of the United States total population, African Americans were 51% of all new HIV diagnoses between 2001 and 2002.[31] These

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[29] See Chapter Two for the issues related to the face of HIV/AIDS in the African American community, including discussion on the so-called "men on the down low."

[30] See Table A.2 mentioned earlier in this chapter and found in Appendix A.

[31] CDC, *CDC Media Facts- Fighting HIV among African Americans: A Heightened National Response* (Atlanta, GA: CDC, March 2007), 1.

new diagnoses may have come from persons recently or long ago infected. In 2005, 49% (or 18,510) of all new diagnoses (an estimated 38,096) were made in African Americans in the thirty-three states with long-term confidential name-based testing.[32] Table B.1 in Appendix B shows cumulative HIV infection cases for Virginia at 9,277 and North Carolina at 11,560 (overall state data without regard to race/ethnicity or age) at the start of this project, compared to cumulative infection cases in the United States (i.e., 199,759 cases through December 2002).

Cumulative reported HIV cases all ages through 2004 for all states with confidential name-based reporting shows that North Carolina was ranked fifth (12,368 cases) and Virginia sixth (9,209 cases), with total United States cases at 229,411.[33] In addition, for children less than age thirteen during the same reporting period, North Carolina ranked seventh (132 cases) and Virginia, twelfth (88 cases), with total United States cases at 4,814.[34] Annual 2004 reported HIV cases all ages ranked North Carolina seventh (1,099 cases) and Virginia, ninth (858 cases). Data presented "includes only persons with HIV infection that has not progressed to AIDS," and "includes data from 37 states and from U.S. dependencies, possessions, and independent nations in free association with the U.S."[35] Virginia initiated reporting in 1989 and North Carolina in 1990. Maryland and the District of Columbia did not report during the 2004 period.[36]

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[32] CDC, *CDC HIV/AIDS Fact Sheet: HIV/AIDS among African Americans, January 2007*, 1.

[33] The Henry J. Kaiser Family Foundation, "Cumulative HIV Infection Cases Reported through 2004 among states with Confidential Name-Based Reporting," http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=HIV%... (accessed November 15, 2006) The Data search was ranked by cumulative reported HIV cases all ages. The original CDC data source is available at http://www.cdc.gov/hiv/stats/2004SurveillanceReport.pdf.

[34] Ibid. The data search was ranked by cumulative reported HIV cases pediatric.

[35] Ibid. The data search was ranked by annual reported HIV cases all ages.

Data from the Maryland AIDS Administration, indicated that approximately 2,200 new infections were detected yearly since reporting began in 1994, with 14,967 Marylanders living with HIV (without AIDS) as of June 30, 2003.[37] Maryland also reports that as of June 30, 2003, there were 27,207 people in the state living with HIV/AIDS (cases reported through June 30, 2004).[38]

Among those under age 25 (i.e. ages 13-24), whose diagnoses was HIV/AIDS during the period 2001-2004, 61% (11,554) were African Americans of the 18,849 people in this category in the thirty-three states reporting.[39] In addition, African Americans infants constituted the majority (65% or 91) of the 141 infants perinatally (mother-to-child) infected in based on unpublished CDC reporting data in December 2006.[40]

AIDS Cases

UNAIDS data revealed that there were 680,000 to 1 million adults and children living with HIV/AIDS in the United States at the end of 1999.[41] In contrast, data for fifty states and the District of Columbia for AIDS cases only from a CDC Surveillance Report for 2005 indicated that there were 425,910 people in the United States living with

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[36] Ibid.

[37] Maryland AIDS Administration, "Statistics," www.dhmh.state.md.us/AIDS/epictr.htm, (accessed Fall 2004).

[38] Ibid.

[39] Ibid.

[40] Ibid.

[41] UNAIDS, *June 2000 Report*, 133.

AIDS.[42] African Americans comprised 44% (or 188,077) of this group.[43] "Since the beginning of the epidemic (in the 1980s), African Americans have accounted for 399,637 (42%) of the estimated 956,666 AIDS cases diagnosed in the 50 states and the District of Columbia."[44]

Appendix Table B.2 shows the most recent HIV/AIDS data available at project initiation through December 2002. Of the 859,000 confirmed AIDS cumulative cases (from the start of surveillance or official reporting on AIDS epidemic) in the United States, the Second Episcopal District location with the largest number was found in the District of Columbia (25,358). Likewise, the District of Columbia had the largest number of new AIDS cases among African Americans (1,563).

Overall the states/district in the comprising the Second Episcopal District had 67,582 cumulative AIDS cases and 4,119 new AIDS cases among African Americans. Additionally, Maryland AIDS Administration data reported that Baltimore had the fourth highest AIDS case report of any major metropolitan area (48.7 cases per 100,000 population in 2002).[45] In 2005, CDC reported that the rate of African American AIDS diagnoses for adults and adolescents was ten times the rate of whites and nearly three times the rate of Hispanics. Furthermore, there was a twenty-four times higher rate of AIDS diagnoses among African American women than white women and an eight times

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[42] CDC, *CDC HIV/AIDS Fact Sheet: HIV/AIDS among African Americans, January 2007*, 2.

[43] Ibid.

[44] Ibid.

[45] Maryland AIDS Administration, "Statistics," www.dhmh.state.md.us/AIDS/epictr.htm, (accessed Fall 2004).

higher rate for African American men compared to white men.[46] Compounding this, the poor nine-year survival rates of African Americans compared to other ethnic and racial groups as shown in Table B.3. From the beginning of the epidemic until December 2005, there were an estimated 211,559 African Americans who died with AIDS.[47]

Special Issues

Several topics deserve special attention including: MSMs, especially college students and those who are bisexual; infection and incarcerated or previously incarcerated persons; and abstinence programs. Together, these issues pose opportunities and challenges for members of the faith community.

A study published in 2004 generated widespread alarm. The article was entitled "HIV Transmission Among Black College Student and Non-Student Men Who Have Sex With Men – North Carolina, 2003."[48] A statistically significant increase from two acute HIV infection cases among college students in the year 2000 to 56 cases from January 2001 until May 2003 was revealed through a retrospective study. The majority of the 56 (49 or 88%) were black, ages 18-30, nearly all MSM including some who were having sex with both men and women.[49]

The North Carolina Department of Health and CDC conducted an epidemiologic investigation to determine behavioral risk factors for HIV infection in young black MSM,

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[46] Ibid.

[47] Ibid.

[48] CDC, *Morbidity and Mortality Weekly Report (MMWR), August 20, 2004*, 53(32), 731-734, www.cdc.gov/mmvrhtml/mm5332al.htm, (accessed October 2004).

[49] Ibid., 1.

including both quantitative and qualitative (interviews as well as three focus group discussions with 60 male and female students at 11 North Carolina colleges). The most common reasons given for high risk behavior included: "1) lack of sustained prevention messages targeting young blacks, 2) feeling personally disconnected from the reality that they might contract HIV, and 3) believing that physical characteristics and appearance can inform one about their partner's HIV status."[50] Because two Annual Conferences in the Second Episcopal District are located in North Carolina, and AME churches surround most college campuses, this study has tremendous implications for outreach and inreach efforts in this ministry project.

Another area of high concern is the infection rate among persons incarcerated currently or previously. A book underscoring this fact was written by Dr. Eric Goosby, former Director of the Office of HIV/AIDS Policy in the United States Department of Health and Human Services and Deputy Director of the National AIDS Policy Office of the White House and the current head of Pangea Global AIDS Foundation.[51] In a candid critique of the problem, Goosby shares, "Young men go into prison healthy and come out with HIV. They bring it back to their wives and girlfriends, and to friends they do drugs with. Some of these men were tested in prison and know they have HIV, but they don't tell anyone because they are ashamed how they got it. They convince themselves that the test result is a mistake."[52]

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[50] Ibid., 2.

[51] Eric Goosby, *Living with HIV/AIDS: The Black Person's Guide to Survival* (Roscoe, IL: Hilton Publishing Company, Inc., 2002, 2006), 15-17.

[52] Ibid., 17.

The statistics support the fact that prisons host large numbers of persons at high risk for HIV infection. According to the United States Department of Justice, AIDS prevalence among United States prisoners was three times that of the general population in 2004. Prison is considered a risk factor in light of "tattooing, unsafe sex, and drug injection practices by some prison inmates, coupled with the sexual relationships, and socioeconomic consequences faced by persons with histories of incarceration."[53] Recent CDC plans to address this concern include: "investigating prevention needs and strategies for HIV-infected and uninfected African American male prison inmates during transitions into and out of prison, including HIV risk behaviors, access to HIV testing, access to prevention interventions, and access to HIV care and treatment services."[54]

The issue of abstinence continues to be a topic of importance in faith communities, and in education systems. This ministry researcher applauds programs such as the historic ABC program (i.e., **A**bstinence, **B**e faithful and use **C**ondoms), which was among the programs that obtained great success in reducing HIV/AIDS rates in the Uganda.[55] Recent United States federal grants have been directed at increasing abstinence programs. This is needed as a first line of events against HIV and AIDS; however, this ministry researcher advocates broader approaches in light of the devastating rates in the United States among African Americans, especially those of all ages who are sexually active. Discussion and related action on this issue needs to continue.

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[53] CDC, *A Heightened National Response to the HIV/AIDS Crisis Among African Americans* (Atlanta, GA: United States Department of Health and Human Services, Centers for Disease Control and Prevention, March 2007), 2.

[54] Ibid., 7.

[55] UNAIDS, *June 2002 Report*, 8-10. This reference provides summaries of Uganda's progress in response to HIV prevalence trends.

CDC's budget for fighting HIV in African American communities is $300 million; nearly half of CDC's HIV prevention budget, with the intent to increase the amount announced such as President George W. Bush's proposed 2008 budget line item of $63 million to expand HIV testing efforts.[56] Still, the high rates of HIV/AIDS and the special issues impacting them led the CDC in March 2007 to identify four priority areas for the national response: 1) expanding the reach of HIV prevention services; 2) increasing opportunities for HIV diagnosis and treatment; 3) developing new, effective interventions; and 4) mobilizing broader community action.[57] CDC's mobilization plans include holding forums in ten Southern cities to help churches "identify specific actions they can take to support prevention efforts, encourage HIV testing, and reduce the stigma of HIV."[58] The CDC's intensified efforts in mobilization make this ministry project, extremely timely and relevant.

Emergence of the SHINE Global Model for Second Episcopal District Mobilization for HIV/AIDS Prevention and Care Efforts Using Government and Faith-based Initiatives

As a result of lessons learned in the spiritual pilgrimage, academic training and professional experiences, and in consideration of the context for ministry, the SHINE Global Model for Mobilization of An Episcopal District for HIV/AIDS Prevention and Care Efforts Using Government and Faith-based Initiatives was created. SHINE is the acronym for Spiritual Growth and Maturity, Health and Wholeness, Insight, Networking

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[56] CDC, *A Heightened National Response,* 2 and 4.

[57] Ibid., 3.

[58] Ibid., 5.

and Empowerment. Special attention was paid to incorporating in the model: government; community; and faith-based initiatives that influence awareness programs at various levels (i.e., local, regional, national and international).

The term "shine" was used in remembrance of a greeting commonly used in AME churches in Botswana during the international HIV/AIDS conference.[59] After introduction of a person, a leader would say, "Give him/her a shine." The congregation would respond "shine!" In light of the gloomy statistics of HIV/AIDS pandemic, the ministry researcher thought shine as an acronym provided a necessary light to the situation and conveyed a sense of hope. Furthermore, a biblical basis for action could be found in Matthew 5:16 (KJV), "Let your light so shine before men, that they may see your good works, and glorify your Father which is in heaven."[60]

The SHINE Global Model is summarized on the next page in Figure 1. Included are examples of types of events. Further information is provided in the methodology section in Chapter Four.[61] The SHINE Model encompasses many lessons learned and proven strategies and faith-based health models experienced by the ministry researcher. Some of the ministry models are presented in the next chapter, "Chapter Two – Church Health Programs: State of the Art of This Ministry Model."

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[59] See also earlier reference in "Spiritual Pilgrimage" to the Eighteenth Episcopal District Conference in Botswana (Page 15).

[60] The term "shine" has also been incorporated into a youth projects developed by the ministry researcher while in college, and implemented in local congregations in Maryland and the District of Columbia. Early components of the SHINE Model tailored for youth work included: spiritual growth and maturity, health and wholeness, educational excellence and wisdom, leadership development, social justice and community action. At the time of this writing, the "Realize Your Promise – SHINE" Youth Ministry is still operational at Pilgrim AME Church in Washington, DC. This ministry began in 2002 when the researcher served as Director of Youth Ministries and during the early phases of this doctoral project. The youth provided regular inspiration, and work with them reinforced the importance and urgency to share HIV/AIDS prevention with all generations.

[61] In addition, Chapter Six contains a summary of mobilization efforts organized by SHINE focal area.

Figure 1: SUMMARY OF SHINE HIV/AIDS MODEL FOR GLOBAL FAITH-BASED MOBILIZATION EFFORTS

Using the SHINE Global Model focal areas, this figure provides examples of health or disease-specific activities conducted in an Episcopal District to raise awareness on issues related to HIV/AIDS.

S – SPIRITUAL GROWTH AND MATURITY

Corporate Events – Annual Conferences, District Conferences and other meetings within an Episcopal District, Worship and Prayer Services

Personal Devotion – Individual acts that strengthen one's faith in God

H - HEALTH AND WHOLENESS

Prevention Activities (e.g., public awareness campaigns, HIV testing, abstinence, promotion of monogamous relationships, condom usage and other prevention methodologies)

Care Activities (e.g., access to health care, treatment, support services such as case management, counseling, food and financial assistance)

I – INSIGHT

Access and use of information and technology to develop innovative strategies to raise awareness of HIV/AIDS (e.g., videos, DVDs, CDS, webcasts)

Compilation of lessons learned and recommendations to advance HIV/AIDS outreach and inreach activities.

N- NETWORKING

Collaboration with churches and others in the faith-based community

Engaging in dialogue and engaging in strategic partnerships with members of the public and private sectors including businesses, professional organizations and governmental agencies at the local, state, federal, regional, federal and international levels.

E – EMPOWERMENT

Interventions that enhance sustainability such as activities that support infrastructure enhancement, intergenerational involvement, and other avenues to incorporate HIV/AIDS prevention and care and overall healthy practices into overall church life.

CHAPTER TWO

CHURCH HEALTH PROGRAMS: STATE OF THE ART OF THIS MINISTRY MODEL

This chapter is divided into three components: 1) early church leaders engage in healing; 2) an overview of church health programs and models; and 3) a case for HIV/AIDS faith-based interventions.

Early Church Leaders Engage in Healing

The teachings and practices of Jesus the Christ exemplified the need for spiritual leaders to be engaged in healing and care for all, especially the poor and marginalized. The early Christian leaders recognized this role and adopted healing as a part of the functions of the church leaders. Many healings were reported in the Acts of the Apostles, including healing by evoking the name of Jesus.[1] James, the half-brother of Jesus, underscores this as he wrote, ". . . Is any one of you sick? He should call the elders of the church to pray over him and anoint him with oil in the name of the Lord. And the prayer offered in faith will make the sick person well; the Lord will raise him up. If he has sinned, he will be forgiven . . ."[2] Gene Getz provides an explanation of this passage (and other healing texts), and argues that in this text, the welfare of believers was the focus

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[1] Examples include: Acts 3:1-10, 9:32-35 (in the name of Jesus); and Acts 5:16, 8:5-8 (summaries of healings/miracles). Further discussion on the Apostles acts of healing is found in: Harold Remus, *Jesus as Healer* (Cambridge, United Kingdom: Cambridge University Press, 1997), 99-101.

[2] James 5:13-16 NIV

and healing for the soul and body.[3] By putting the sick back in the hands of a group of elders (versus just a priest or in isolation as prescribed by modern medicine), Abigail Evans points out that the persons are placed back in the center of the love of the community.[4] The key point for this mobilization project is that church leaders knew it was their function to pray, anoint with oil and heal, and acted accordingly.

As shall be addressed in the biblical foundation in Chapter Three, epidemics caused the church to be engaged not just as spiritual healers of the physical body, but also as partners in medical care who are deeply spiritual. This distinction is seen as the Christian church assumed new levels of awareness and organization to address pain.

An Overview of Church Health Programs and Models

In 1990, a report of a study by the Christian Medical Commission of the World Council of Churches was published that included descriptions of the congregation as a healing place, a caring community, a health teaching place, and an advocate for justice, peace and integrity of creation.[5] A challenge was put forth to congregations to engage in primary heath care (PHC):

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[3] Gene A. Getz, *Elders and Leaders: God's Plan for Leading the Church* (Chicago, IL: Moody Publishers, 2003), 61-64, 331-340.

[4] Abigail Rian Evans, *The Healing Church: Practical Programs for Health Ministries* (Cleveland, OH: United Church Press, 1999), 4. Additionally, Evans traces the church's differing perspectives on healing during the Reformation period, and John Calvin and Martin Luther's distinction made from Roman Catholic sacrament of extreme unction (preparation for death). Furthermore, this author describes how after the Reformation, monasteries and related "hospitals" closed and, in the West, religion and medicine separated (Ibid., 9-14). Despite some voluntary Christian hospitals remaining open, this separation continued, according to Evans, until the modern era's medical missionary movement and then the health ministries in the 1970s (Ibid., 14-18).

[5] Christian Medical Commission, World Council of Churches, *Healing and Wholeness: The Churches' Role in Health* (Geneva, Switzerland: Christian Medical Commission, World Council of Churches, 1991), 31-32.

> as a means of correcting the existing unjust distribution of health care resources . . . persons in all places of the world can be empowered to discover the causes of most of their illness and treat them. In addition, they can learn early treatment in the home or community for many illnesses. Through PHC the heavy dependence on professional and institutional health services can be lifted, allowing them to provide expert care for the complicated illnesses for which they are trained and equipped.[6]

The congregation was also "challenged to recognize, support and cooperate with healing partners such as: family, health professionals, traditional and alternative healers, other agencies and communities (and) other faith groups."[7] These statements by a world ecumenical body set the stage for widespread partnership of the faith communities and various institutions.

In the decades following, numerous publications to assist congregations in addressing health issues were circulated. Some traditional African American congregations sought to expand the otherwise spiritual functions of the church nurses to include formal health instruction.[8] Specific guides to assist the congregations in starting health awareness were also circulated with the expertise of both registered nurses and physicians.[9] Others, such as the Reverend Dr. Gary Gunderson of the Interfaith Health Program of the Carter Center in Atlanta, Georgia (the official office of former United

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[6] Ibid., 33.

[7] Ibid. (punctuation added)

[8] T. B. Boyd, Jr., *2006 Nurses' Auxiliary Guide* (Nashville, TN: R. H. Boyd Publishing Corporation, 1974).

[9] Kristen L. Russell, Cynthia and Jack Birge, *Congregational Health: How To Make Your Congregation A Health-Aware Community* (Roscoe, IL: Hilton Publishing Company, 2003).

States President Jimmy Carter), have used more conceptual approaches to understanding congregational roles in health.[10]

Within the United States, formal partnerships between faith groups and health agencies were notable in the 1990s during former Presidents' George Bush and William Jefferson Clinton administrations. The ministry researcher witnessed firsthand memoranda of understanding between the United States, Department of Health and Human Services and the Department of Transportation with an African American religious coalition to address a multitude of health concerns and safety issues.[11] Under the administration of President George W. Bush, an Executive Order was issued that further set the stage for creation of Faith-based and Community Centers in various government agencies.[12]

The term "faith-based initiatives" has now become widely popularized, referring to engaging the faith groups to varying degrees in different projects, typically referring to those with the government. This ministry project is evidence of the partnership between African American communities of faith and the Office of Minority Health, United States Department of Health and Human Services. With over fourteen years experience participating in and managing health programs, the ministry researcher used insights gained to design the SHINE Global Model for this project. Key lessons learned from nine church health models (i.e., the TIME Model and eight others) are summarized below and were taken into consideration in the SHINE design.

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[10] Gary Gunderson, *Deeply Woven Roots: Improving the Quality of Life in Your Community* (Minneapolis, MN: Augsburg Fortress Publishers, 1997).

[11] These agreements were with the former Congress of National Black Churches, Inc., a coalition of eight historically black denominations.

[12] George W. Bush, *Rallying the Armies of Compassion* (Washington, DC: United States Government, January 2001).

The perspective in which one operates a health program is critical to a program's success. The ministry researcher developed the TIME Model to address immunization awareness and interventions for pre-school children, adolescents and adults.[13] TIME is an acronym which stands for: T- Trust (You Can Count on Me), I- In-person Contact (I Understand Your Concerns), M-Mode of Entry (Let's Work Together through A Church and Community Action Plan), and E- Existing Organizations and Ministries (Let's Make Our Efforts Last – Sustainability). The basic premise of the model is that relationships take T-I-M-E. Each component of the TIME Model has questions to ask participants and supporters of a project to ensure that the planning, implementation and evaluation is consistent with real and perceived needs and includes an approach for maximum efficiency, effectiveness and acceptance of the primary target audience.

Of the many church health models, the ministry researcher previously categorized them into several areas. These are described below with a summary of key components.

1. *Annual and Periodic Church Event* – church health fairs, seminars or support of national health awareness days such as World AIDS Day or National Take Your Loved One to the Doctor Day.
2. *Community and Academic Support* – Church leaders and congregations support local institutions by providing volunteers, financial assistance,

[13] This model was developed while serving as Project Director for the "Give Your Child A Shot At Life" Pre-School Immunization Campaign and later programs with adolescents and adults. This project was operated under the auspices of the former Congress of National Black Churches, Inc. in a cooperative agreement with the United States Department of Health and Human Services, Centers for Disease Control and Prevention, National Immunization Program. Presentations on the TIME Model have been made to faith communities, government agencies and health professionals across the United States.

public awareness and referrals. Such collaboration often results in resource materials to aid the faith community.[14]

3. *Advocate* – A church leader or faith-based organization works to protect the rights and services of the poor, disenfranchised or abused persons. Examples of areas include: access to health care/health insurance, fair and non-discriminatory services, hiring practices, cost increases or service reduction. Discussion of these issues is often entered into by concerned citizens and is educational in nature. They generate public awareness and are not meant to violate non-profit regulations (e.g., for 501(c)3 organizations) against practices such as lobbying. The Concerned Black Clergy of Metropolitan Atlanta, Inc. (CBC) has a well established history or organizing church and community leaders to address issues of social justice, economic, educational and health importance.

4. *Church Coalition/Ministerial Alliance* – A group of churches or ministers/clergy meet regularly to address issues of concern. The Clergy United for the Renewal of East Baltimore (CURE)/Heart, Body and Soul, Inc. (HBS) has sustained local residents' participation and has received funding from public and private sources such as the W.K. Kellogg Foundation. By collaborating with entities such the Johns Hopkins Medical Institutions, American Cancer Society, local community organizations and the federal Bureau of Primary Health Care, CURE/HBS

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[14] Examples include: 1) Jennifer Shifrin, ed., *Mental Illness Awareness: The Bible As A Resource for Sermons and Articles* (St Louis, MO: Pathways to Promise, 1997); and 2) Joan Chamberlain Engelsman, ed., *Helping Victims of Domestic Violence: A Guide for Religious Leaders* (Madison, NJ: The Clergy Partnership on Domestic Violence, 2000).

has strengthened its efforts to promote screening, health education, monitoring, referrals and local outreach, as well to replicate its work.[15]

5. *Integrated Ministry* – Health initiatives are incorporated in the activities of other ministries. A senior citizen's ministry or senior choir may promote flu or pneumonia vaccinations. A Women's Missionary Society (WMS) promotes HIV/AIDS awareness as a part of its programming.[16]

6. *Cluster* – A geographic representation of individuals, churches or organizations aligned. In many instances the clusters may also be church coalitions or ministerial alliances. An example Western Maryland Cluster of the Capitol District of the Washington Annual Conference, AME Church conducts health seminars and disseminates educational and promotional materials to constituents.

7. *Health and Wholeness Committee* – Ministries of local churches charged with raising awareness within the congregation. Health newsletters, Sunday bulletin alerts, seminars etc. Names of the committees may vary (e.g., wellness or health committee, names with historical or congregational significance, or by specific health areas or topics like HIV/AIDS or caregivers support groups).[17] These committees/ministries

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[15] An overview of the approach is found in *A How-To Guide of CURE/Heart, Body and Soul, Inc.: A People-Work in Progress* (Baltimore, MD: CURE/Heart, Body and Soul, 1996). The Reverend Melvin Tuggle, II, previous president, and other East Baltimore clergy have been instrumental in raising awareness of church health programs in local, regional and national arenas.

[16] Further examples of HIV/AIDS activities of the WMS of the AME Church are recorded in Chapter Three, the section on historical foundation entitled "HIV/AIDS Pandemic."

[17] For a presentation on a specific ministry and its function see: Edwin Harvey Hamilton, "The Health and Wellness Ministry in the African American Church Preventive Health Education" (DMin, United Theological Seminary, 1997).

may regularly utilize biblical teaching tools, other Christian educational resources and devotional guides to supplement members' spiritual growth and development.[18]

8. *Specialized Training/Continuing Education* – Many medical schools and seminaries now offer courses on health, medicine and spirituality to further equip clergy and church leaders to address health concerns. For example, the Virginia Union University, Samuel DeWitt Proctor School of Theology offers a "Substance Abuse Ministry" course and faculty have collaborated with the Virginia Commonwealth University/Medical College of Virginia. The Spirituality and Medicine Program of the Howard University Hospital's Department of Community and Family Medicine Department provides ongoing training opportunities for clergy and health/medical professionals.

It is possible for a given church to execute its health activities by involving elements from two or more models. For example, a noted public health professor, Dr. John Hatch, described a health planning conference to address teen pregnancy in the African American community sponsored by the General State Baptist Association in

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[18] Sample references include:

a) Louise Giroux, *A Mind and Heart for Wellness* (Kelowna, British Columbia: Northstone Publishing, Inc., 1998);

b) AME Church, Department of Church Growth and Development, *The Secret Chamber Daily Devotional Guide, July-December 2005* (Memphis, TN: African Methodist Episcopal Church, 2005). (The guide includes entries supporting the 2005-2006 Quadrennial Focus on "Living Well");

c) Mary Baker Eddy, *Science and Health with Key to the Scriptures* (Boston, MA: The First Church of Christian Scientist, 1875) latest copyright renewed, 1934; and

d) American Bible Society, *The Lord Hears Your Cries: Hope and Strength from the Scriptures in the Midst of Domestic Violence (Contemporary English Version)* (New York: American Bible Society, 1995).

North Carolina with consultants from the University of North Carolina – Chapel Hill.[19] Of the eight models outlined by the ministry researcher, this conference and its outcomes, likely included components from four models (i.e., Church Coalition/Ministerial Alliance, Cluster, Health and Wholeness Committee, and Specialized Training/Continuing Education). The various church health program models presented above provide ideas for collaboration, local organization and suitable strategies for the SHINE Global Model which seeks to mobilize constituents in an AME Episcopal District.

A Case for HIV/AIDS Faith-based Interventions

HIV/AIDS was described statistically in Chapter One, along with the ministry researcher's firsthand experience in various ministry and educational settings. In this section, the face of AIDS will be discussed in light of the unique ministry issues for contemporary churches. In the United States in the early 1980s, HIV and AIDS were associated primarily with those were white, homosexual and male. The image of those impacted was broadened with the help of public disclosures of hemophiliacs such as the renowned tennis player Arthur Ashe and HIV+ children like Ryan White (after whom much legislation and subsequent federal treatment funding is named).

Later, the rise in HIV infection among intravenous drug users sounded the alarm that the epidemic was on the rise. Soon revolutionary pilot programs such as needle exchange were raising new ethical issues in an already politically and emotionally fueled debate. Patricia and Hydeia Broadbent, an African American mother and daughter

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[19] John Hatch and Steve Derthick, "Empowering Black Churches for Health Promotion," *The Journal for Health Behavior, Education & Promotion* 16, no. 5 (September/October 1992): 3-9.

respectively, tell of the challenges bravely endured and advocacies undertaken by the family of the adopted HIV+ daughter (transmitted by her biological mother who was likely an infected intravenous drug user).[20] Hydeia Broadbent reflects on her role as an AIDS activist, "I guess one thing I want people to understand is that you don't have to be a special person to make a difference. When I started, I was just a little girl. No one told me what to say, I just listened to what was in my heart. You just have to believe in what you're doing and find way to get people to listen. And you can change people's lives, even save people's lives. Anyone can do it."[21]

In the twenty-first century, the cure for HIV/AIDS has still not been found, yet advances in treatment methodologies and prevention strategies continue. In contrast to more than twenty years ago, the face of the pandemic in the United States today is predominately African American, heterosexual, and increasingly targeting adolescents, young adults, women and seniors. Those in the faith community must do more than take note, for action is required.

Numerous books, testimonials and videos have been published on the plight of persons living with HIV and AIDS. Bishop Fritz Mutti of the United Methodist Church and his wife, Etta Mae Mutti, have shared their journey in dealing with the life and death of two of their three sons to AIDS, both of whom were homosexual.[22] The book gives insight to the special concerns in a clergy family such as those raised by one HIV+ son

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[20] Patricia Broadbent and Hydeia Broadent, *You Get Past the Tears: A Memoir of Love and Survival* (New York: Villard Books, 2002).

[21] Ibid., 212.

[22] Fritz Mutti and Etta Mae Mutti, *Dancing in a Wheelchair: One Family Faces HIV/AIDS* (Nashville, TN: Abingdon Press, 2001).

who was a seminary student, as well as the parents' hesitancies in sharing with congregations and friends and difficulties in introducing a resolution in 1986 Missouri West Annual Conference and the subsequent opportunities at the 1987 United Methodist Church national consultation on AIDS ministries held in San Francisco, California.[23]

With a rise in African American female HIV infection rates, recent dialogue has centered on one probable cause, the men who are so-called "on the down low." This term refers to men who consider themselves "straight" or heterosexuals, but who secretly have sex with other men. "Men on the down low" was made popular by the widely publicized book by James King.[24] One college student conveys concern, "Who are you supposed to date? So many guys are gay and embarrassed to be. I don't really care about that so much. I do care that they are pretending to be straight and that means, that like most sisters, I have to (sort through them) and guess whether or not I am putting myself at risk unnecessarily."[25]

Even a fictional book published as a part of the "Rap-It-Up" initiative of Black Entertainment Television (BET) candidly depicts the life challenges of three African American couples and families, and provides insight on the complexity of HIV/AIDS issues such as: sustaining a relationship with an HIV+ partner and is marriage out of the

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[23] Ibid., 24-26, 32-33, 40, 44-45.

[24] James King and Karen Hunter, *On the Down Low: A Journey into the Lives of "Straight" Black Men Who Sleep with Men* (New York: Broadway Books, 2005).

[25] A quote by Dawn A. Mitchell in an article by Shantella Shermon a Jackson State University student in the magazine *Ledge*, Volume 1, Issue 1 (Los Angeles, CA: Black AIDS Institute, Inc., Fall 2004), 8.

question; love, alienation and HIV; and foster care and adoption considerations.[26] With all the attempts to raise awareness on HIV, controlling its spread is still is an uphill battle.

The media, entertainment community, and society in general have fostered a highly sexual climate, yielding a glorification of sex and high risk, unprotected behavior which, in turn, may influence HIV/AIDS rates. On the other hand, the faith communities, based on moral grounds, have sometimes remained silent in the sexuality discussions. The reality is with the advent of HIV/AIDS the church leaders must become more informed and identify contextually appropriate ways to address sexual issues such as both abuse and addiction. This section is by no means intended to imply that persons who contract HIV have obtained it as a result of a sexual addiction. However, the purpose is to demonstrate the complexities of sexual issues that sometimes underlie the struggles of those who fall victim to HIV/AIDS or who are in relationships that put them at high risk.

The cycle of sexual addiction includes preoccupation, ritualization, compulsive sexual behavior, shame, despair and guilt.[27] Table 2.1 outlines the levels of sexual addiction that should enter the knowledge base of those seeking to have deeper insight into the counseling and other support issues of those who are addicted to sex.

As one examines the various levels of sexual addiction, emotions may evolve such as disgust, shock, fear or anger. Where sexual abuse is involved, other infringements may also be present. Eugene and Poling point out other abuse forms present in African American (as well as other) families include emotional and physical abuse, as well as

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[26] Joyce D. Davis, Mikel Husband and Kendra Lee, *One Hand in My Pocket* (Washington DC: BET Publications, LLC, 2001).

[27] Lee N. June, Sabrina D. Black and Willie Richardson, *Counseling in African-American Communities: Biblical Perspectives on Tough Issues* (Grand Rapids, MI: Zondervan, 2002), 37-38.

destructive acts.[28] Members of the faith community should be sensitized to the pain of many reached and unreached persons in the community. Not only do people long for those to help them cope and address abuses and hidden dangers such as HIV, they often desire people to at least be familiar with their lifestyles. Familiarity or expressions of caring do not constitute endorsement of a particular behavior.

Table 1. Levels of Sexual Addiction *

Level**	Description
One	Culturally Perceived Acceptable Behavior - masturbation, multiple heterosexual and homosexual relationships, pornography and prostitution
Two	Nuisance Behavior – being an exhibitionist, a voyeur, or a transvestite; engaging in bestiality; taking indecent liberties; and making indecent phone calls.
Three	Sexual behavior that is dangerous, abusive, or life threatening including incest, child molestation, sexual abuse of vulnerable adults and rape. Often-overlooked out-of-control sexual behavior such as having multiple affairs (fornication/adultery), dangerous sexual practices, anonymous sex, compulsive sexual episodes and intensive vicarious experiences.

* Taken from an article, "Sexual Addiction and the Internet" by Sabrina D. Black and Lavern A. Harlin in the book by June, Lee N., Black, Sabrina D. and Willie Richardson, *Counseling in African-American Communities: Biblical Perspectives on Tough Issues.* (Grand Rapids, MI: Zondervan, 2002), 39.
** The authors note that an individual may not necessarily progress from one level to another or even start at level, but it depends on the "individual appetites."

A reality check is sometimes needed for those who think Sundays are just for going to church. HIV is lurking to infect its next victim just as the processional occurs, the choir sings, the preacher gives the sermon, offering is taken, or the altar prayer is rendered. This poem/reflection by Jill Scott captures this sentiment in her "One Second of Warped Security":

I was chillin' with him on a Sunday

[28] Toinette M. Eugene and James Newton Poling, *Balm for Gilead: Pastoral Care for African American Families Experiencing Abuse* (Nashville, TN: Abingdon Press, 1998), 61-63.

It was a good day
All day making love day
I didn't think that I could feel that safe
That comfortable, that secure, but I did
And HIV came to visit[29]

In order to create effective faith-based interventions to reach persons infected or affected by HIV/AIDS, a strategic approach is needed that takes into consideration perspectives that sometimes are pitfalls in projects dealing with sensitive topics. Certainly, persons engaged in HIV/AIDS interventions must demonstrate that they genuinely care about participants. Dr. John Trent's book explains relationship killers defined earlier by Dr. John Gottman of the University of Washington in Seattle as four horseman (as in the book of Revelation): 1) criticism; 2) contempt; 3) defensiveness; and 4) stonewalling.[30] Although Gottman originally used these factors as a five-minute predictor of divorce, they may also predict factors that will kill an HIV/AIDS project and resultant relationships.

Strategies Yamamori suggests for unreached peoples in the missions field may also prove appropriate for faith communities' work with persons not traditionally a part of their ministries. These strategies are: 1) vision; 2) identification; 3) prayer; 4) adoption; 5) mobilization; 6) training; 7) engagement; 8) assessment; and 9) partnership.[31] In addition, since HIV/AIDS is a crisis that has global implications,

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[29] Jill Scott, "One Second of Warped Security" *Ledge*, Volume 1, Issue 1, 2004 (Los Angeles, CA: Black AIDS Institute, 2004), 29.

[30] John Trent, *Be There! Making Deep, Lasting Connections in a Disconnected World* (Colorado Springs, CO: Waterbrook Press, 2000), 189-193.

[31] Tetsunao Yamamori, *Penetrating Missions' Final Frontier: A New Strategy for Unreached Peoples* (Downers Grove, IL: Intervarsity Press, 1993), 83-85.

other development tactics in situations of need give insight for project initiation. Examples of these development tactics include: 1) high selectivity in staffing; 2) impartial giving; 3) staying nonpolitical; 4) not rushing the evangelism; 5) supporting indigenous churches and Christ groups; 6) leaving in time; 7) visible prayer-centeredness; 8) no strings attached; 9) cooperation; 10) linking up with the radio (or whatever local media is available); 11) making use of the work of Bible translators (or contemporary versions of the Bible); 12) a reminder again-dependence on prayer; 13) playing fair with governmental agencies that want to support relief but not evangelism.[32] These tactics provide helpful guidance for building and establishing relationships with individuals, families and communities, as well as public and private institutions.

A variety of factors are essential in evoking an appropriate tone and outlook for ministry to persons that some would call hard to reach populations. As noted above, for members of faith communities, all approaches employed should include considerable prayer by those volunteering and for those participating in projects. Larry Dossey M.D., discusses the scientifically proven efficacy of prayer that has been a part of the faith of countless persons throughout time.[33] Others have emphasized the importance of showing compassion and a sense of partnership in healing of those who are ill.[34]

Charles Allen offers a reflection on the Beatitudes that expresses this, specifically Matthew 5:8 (KJV), "Blessed are the pure in heart: for they shall see God."[35] Allen offers

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[32] Ibid., 115-127.

[33] Larry Dossey, *Healing Words: The Power of Prayer and the Practice of Medicine* (New York: Harper Collins Publishers, 1993).

[34] Beverly Musgrave and John R. Bickle, eds., *Partners in Healing: Bringing Compassion to People with Illness or Loss* (New York: Paulist Press, 2003).

three kinds of sight: 1) physical vision (with the natural eye), 2) mental sight (with understanding) and 3) sight from the heart with truth.[36] It is the latter sight from the heart that Allen argues that Jesus used when he displayed compassion and when Mary Magdalene, a prostitute, loved Jesus with her heart and became pure (as evidenced by her seat beside Mary, Jesus' Mother, and at the foot of the cross and being chosen to be bearer of the Good News after the resurrection).[37] Pure hearts should be used in our caring of those infected and affected by HIV/AIDS.

Pure hearts in those who are mobilized for action helps them serve and yield other liberated persons. In describing various dimensions of liberation, Anne Wimberly states that, "Liberation requires that persons experience respectful and just treatment by others, including family, friends, and others with whom they have daily contact (Dimension Four) . . . persons are never fully liberated until they become aware of others' needs for liberation and accept as obligatory their responsibility for contributing to the liberation of others (Dimension Eight)."[38]

In Mark 1:30-31 when Jesus heals Simon's mother-in-law who was sick with fever, she in turn serves them. Bishop Joseph A. Johnson, Jr. of the Christian Methodist Episcopal (CME) Church refers to this text and concludes, "Jesus is saying to his

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[35] Charles Allen, *God's Psychiatry: Healing for the Troubled Heart and Spirit* (Old Tappan, NJ: Fleming H. Revell Company, 1953), 148-152.

[36] Ibid., 149.

[37] Ibid., 149-152.

[38] Anne Streaty Wimberly, *Soul Stories: African American Christian Education* (Nashville, TN: Abingdon Press, 1994), 25-26.

disciples the only way to lift is to touch. You cannot lift men without touching them."[39] Although published in the early 1970s, this statement is relevant to all who have suffered at the hand of the HIV/AIDS crisis that hit a decade later and continues. Bishop Johnson further says, "To be a Christian is to stand with Jesus and participate in His ministry of love and liberation at the crossways of the world where men are crucified in the crosses of poverty, racism, war and exploitation."[40] The crosses people bear today also include disease, disability and destruction of lives, often due to lack of information, immediate action and appropriate spiritual support and guidance through their challenges.

HIV/AIDS ministries have developed worldwide in response to the heavy weight felt by persons of various races, ages, nationalities and sexual histories. In 1996, the World Council of Churches issued a statement on "The Impact of HIV/AIDS and the Churches' Response."[41] Further publications to assist faith communities are numerous, dealing with issues such as training for church leaders, caring for persons with AIDS and ministering in light of special issues of HIV/AIDS.[42]

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[39] Joseph A. Johnson Jr., *The Soul of the Black Preacher* (Philadelphia, PA: Pilgrim Press, 1971), 71.

[40] Ibid.

[41] "The Impact of HIV/AIDS and the Churches' Response," *The Ecumenical Review*, 49 (1997): 270-276.

[42] Examples of HIV/AIDS support materials include:

a) Map International, *Choosing Hope: Understanding Hope Through Knowing Facts About HIV/AIDS* (Nairobi, Kenya: Map International, 1996) (Curriculum Modules for Theological and Pastoral Training Institutions);

b) Daniel E. Fountain, *Care of Persons with AIDS in a Christian Hospital* (Valley Forge, PA: International Ministries, American Baptist Churches, 1995);

c) Anton M. Somlai, Timothy G. Heckman, Jeffrey A. Kelly, Gregg, W. Mulry, and Kenneth E. Multhauf, "The Response of Religious Congregations to the Spiritual Needs of People Living with HIV/AIDS." *The Journal of Pastoral Care*, Winter 1997, 51:4, 415-426; and

d) Wendell Hoffman, W. and Stanley J. Grenz, *AIDS: Ministry in the Midst of An Epidemic* (Grand Rapids, MI: Baker Book House Company, 1990).

In the next chapter, the theoretical foundations for churches and others to engage in HIV/AIDS prevention and care are presented. Additional references for HIV/AIDS work, including those published by the AME Church, are provided.

CHAPTER THREE

THEORETICAL FOUNDATIONS FOR ACTION

The theoretical basis for this project is four-fold: 1) biblical, 2) historical, 3) theological, and 4) ethical. Each component is presented in this chapter with the related implications that provide the foundation for an Episcopal District-wide human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) awareness project.

Biblical Foundation

The biblical foundation used in this project for engaging in HIV/AIDS awareness from a multi-cultural, worldwide perspective embraces two major themes: 1) God calls leaders to carryout God's mission to respond to people's concerns and 2) motivation for action should center around communicating God's compassion to others and glorifying God. These two themes will be addressed in the sections that follow. Moreover, the theological and ethical foundations also provide biblical support for the ministry project.

God Calls Leaders to Carryout God's Mission

There are no geographic bounds to the territory that God will cover to rescue, deliver and guide people.[1] God chooses leaders to carryout his mission on earth. These leaders are persons who experience and acknowledge their call by God and are prompted

[1] Exod. 3, 4:27-31, NIV; Matt. 4:12-25, NIV

to operate by faith. An individual leader's scope of service and the required preparation may vary. Nevertheless, their roles are all vital to God's mission. The lives and ministries of Moses and Jesus provide a good demonstration of how God calls and equips leaders. This section presents a biblical precedent for how these two leaders helped recruit others, and gives implications for HIV/AIDS awareness mobilization.

Exodus: A God-Ordained Journey to Aid and Mobilize Oppressed People

Those entrusted with leadership responsibilities must remember that God is in charge and will be with them and equip them for every task. One Old Testament example of this is Exodus chapters 1-4 where God raises up Moses, assisted by Aaron, to respond to the Israelites' (or Hebrews') cries for help from their lives of oppression in slavery in Egypt. These two men are commissioned to go first to the Israelite elders and then to Pharaoh to act on God's behalf to liberate the people.[2] Mobilization requires obedience first and foremost to God, above any external pressures (e.g., other people's desires or commands) as well as internal doubts or insecurities. These external and internal factors may be caused by one's own weaknesses in faith or lack of trust in God.[3]

The God-ordained journey to assist the oppressed people in slavery became initially evident in the bold and heroic act of the Hebrew midwives. These women worked to save the newborn boys, motivated by their fear of God, and consequently,

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[2] We see God's desire to raise up leaders continued, when after Moses' death, Joshua is given a charge to lead the people to possess the promised land across the Jordan River. Joshua, like Moses, went to others to assist him in the mission. Like a commander-in-chief, he went to the officers of the people (i.e., tribal leaders), and then to the priests (Joshua 1, 3, NIV).

[3] Examples of factors impacting Moses are described later and in Table 3.1.

defiance of the king of Egypt's decree.[4] Furthermore, strategies of Moses' mother and sister continued to save the child from governmental mandates for child death. In an ironic twist, Moses was raised as Pharaoh's daughter's son, while being designated to become the God-appointed leader to emancipate the people from Egyptian bondage.[5]

In a bold move, Moses took justice in his own hands and killed an Egyptian who was beating an Israelite. When his deeds were learned, he fled, entering a self-imposed exile state in Midian. For forty years, Moses was a leader who had been set apart to serve, yet was not in the position or environment to act. However, a burning bush encounter with God who was concerned and had heard the Israelites' cries, put Moses on the fast track to mobilize the other leaders for the deliverance from Egyptian oppression.[6] Contemporary burning bush encounters may occur when a person or institution becomes faced with a pressing concern that God is commissioning the leaders to address. HIV/AIDS is such an issue of concern in this ministry project.

Unfortunately, leaders do not always willingly accept their calls. Moses who was once aggressive to assume a leadership role, was now hesitant to take on the God-appointed responsibility to be a conduit for sharing God's concern for those who were suffering. Various fears and insecurities are revealed in Moses' dialogue with God, and are summarized in Table 2. Many of the probable underlying mobilization issues that Moses raised are similar to the reasons some religious/faith leaders give for not becoming

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[4] Exod. 1, NIV

[5] Exod. 2:10, NIV

[6] Exod. 3:1-10, NIV

involved with HIV/AIDS prevention and care efforts. A review of how God responds to Moses issues, gives adequate grounds for refuting objections to an HIV/AIDS ministry project.

Table 2. How God Responded to Moses' Personal Mobilization Issues			
Text	**Moses' Questions and Concerns**	**Probable Underlying Mobilization Issue(s)**	**God's Reply**
Exod. 3:11-12, NIV	"Who am I?"	Insecurity, Low Self-Esteem	"I will be with you."
Exod. 3:13-15, 16-18, NIV	"Suppose I go . . . and they ask me, 'What is his [God's] name?' Then what shall I tell them?"	Questions about authority for action, Need for identification and understanding of who God is, Negative past history and fear of rejection	"I Am Who I Am. . .The Lord, the God of your fathers . . ." "Go assemble the elders . . . The elders of Israel will listen to you."
Exod. 4:1-9, NIV	"What if they do not believe me or listen to me and say, 'The Lord did not appear to you'?"	Insecurities, Fear of failure, Need for approval of others	"What is that in your hand . . .?" - Three miracles to show the people: 1) staff turned to a snake, 2) a leprous hand restored and 3) Nile water turned blood on the ground.
Exod. 4:10-12, NIV	"O Lord, I have never been eloquent, neither in the past nor since you have spoken to your servant. I am slow of speech and tongue."	Insecurity, Uncertainty about one's own skills and abilities	"Who gave man his mouth? Who makes him deaf or mute? Who gives him sight or makes him blind? Is it not I, the Lord? Now go; I will help you speak and will teach you what you what to say."

Table 2. How God Responded to Moses' Personal Mobilization Issues			
Text	**Moses' Questions and Concerns**	**Probable Underlying Mobilization Issue(s)**	**God's Reply**
Exod. 4:13-17, NIV	"O Lord, please send someone else to do it."	Hesitation, disobedience, Loss of self-confidence and failure to put full trust and confidence in God	"Then the Lord's anger burned against Moses and he said, 'What about your brother, Aaron the Levite? . . . You shall speak to him and put words in his mouth; I will help both of you speak and will teach you what to do . . . But take this staff in your hand so that you can perform miraculous signs with it'."

God responded to each of Moses' questions with reassurance that God would be with him. Signs were given by God as tools to boost Moses' confidence and to respond to any questions about authority to speak and act by the Israelites and Pharaoh. Moses' objections and fears blinded him from seeing that his assignment was about God's will being fulfilled to address the cries of the Israelites and not his own abilities. Moses was only an instrument to be used to share God's love and concern for the people. Even when Moses asked for a replacement, God still had Moses be the primary leader with Aaron to assist him. In Exod. 4:27-31, NIV, Moses and Aaron were instructed to be instruments of God to help lead the Hebrew (Israelite) children out of the land of bondage (Egypt). These men were chosen to mobilize their community in a God-ordained mission to liberate the people from slavery.

God is still mobilizing leaders. In a sermon entitled "Welcome to the Ransomed" by Bishop Daniel Alexander Payne, consecrated in 1852 as the sixth AME Bishop who

actively served for 41 years, these statements were made, "For the oppressed and enslaved of all peoples, God has raised up, and will continue to raise up, his Moses and Aaron. Sometimes the hand of the Lord is so signally displayed that Moses and Aaron are not recognized. Seldom do they recognize themselves."[7] The contemporary church must be the catalyst, following the will of God, to spark the recognition and activation of leaders to go serve those in pain due to HIV/AIDS.

In a Bible biography on Moses, John Butler presents in-depth discussion on the ancient leader's struggles in the chapters "Summoned to Service" and "Shrinking from Service."[8] Butler shares that, "When God has to repeat his commands to us, it is an indication that we are being delinquent in obeying. God does not have to repeat his orders to those who are busy doing them."[9] Moses had four summonses to act.[10] Eventually, Moses yielded, and with Aaron, he went to the Israelite elders to begin the process of pain-relief.

In Exod. 3:16-18, NIV, God gives Moses instructions to "Go, assemble the elders" and tells him that "The elders of Israel will listen to you." This is an important mobilization strategy. Instead of going solo, Moses is told to organize with the leaders to prepare for deliverance from captivity. For mobilization projects, the implications of early involvement and participation of key stakeholders or leaders include mass support and enhanced sustainability of program efforts. Butler echoes this, "The first time he

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[7] Cleophus J. LaRue, *The Heart of Black Preaching* (Louisville, KY: Westminster John Knox Press, 2000), 175. The background information on Bishop Payne was taken from the AME Doctrine and Discipline– 2004, 9. The sermon had as its primary text 1Tim. 2:1-4.

[8] John G. Butler, *Moses: The Emancipator of Israel* (Clinton, IA: LBC Publications, 1996, Bible Biography Series Number Twelve), 101-125, 126-146.

[9] Ibid., 140.

[10] Exod. 3:10, 3:16, NIV; Exod. 4:12, 4:19, NIV

(Moses) went out at random to deal with situations (i.e., forty years earlier). Here, he is instructed to start with the elders. When God is in control, things are done more wisely."[11]

In Exod. 4:29-31, God's primary leader, Moses, along with Aaron, met with the elders to share all God told Moses and performed the signs. "(A)nd they believed. And when they heard that the Lord was concerned about them and had seen their misery, they bowed down and worshiped."[12] The result of Moses' ultimate obedience to God's call was that the people believed that God cared, and expressed it by worshiping God. How many more marginalized persons in our society would grow in their faith, if there were more leaders willing to go to them in love?

Faith community leaders must step forward to share God's concern with those who are feeling alienated or unloved. As will be discussed further in the New Testament passage, Christians have a biblical mandate to act and to mobilize to address pain and injustices. All it takes is one sensitized, God-ordained leader to act, through direct and indirect interactions with those in need. This leader can motivate and mobilize countless others. How many appeals for care of the sick and those in pain due to HIV/AIDS do church leaders need in order to respond? How many youth and young adults will put themselves in harm's way with misinformation and premature sexual intimacy? How many funerals will be conducted for persons with HIV/AIDS? Will the number of grandparents and orphanages caring for children left behind after their parents have fallen

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[11] Butler, *Moses,* 119.

[12] Exod. 4:31, NIV

to AIDS continue to grow worldwide? These are some of the relevant questions for leaders of today and tomorrow, who like Moses, Aaron and the elders, are being gathered to confront the HIV/AIDS pandemic.

Matthew 4:12-25: Selected Acts of Jesus to Save and Mobilize

As discussed above, in the Old Testament God sent Moses (and subsequent prophets and godly leaders) to convey his concern for oppressed peoples and to demonstrate mighty acts to liberate them. In the New Testament, we find God the Father's ultimate act of love and concern for humanity. John 3:16, KJV states, "For God so loved the world, that he gave his only begotten Son, that whosoever believeth on him shall not perish, but have everlasting life." Later, Jesus demonstrates a leadership strategy as he calls his disciples following the death of John (Matt. 4:27-31, NIV) that establishes a biblical precedent for mobilization. When one considers the advent of Jesus' earthly ministry following the temptation in the wilderness, he ventures into a series of acts that provide key insights for this ministry project to reach persons infected and affected by HIV/AIDS.

First, Jesus begins by identifying the problem. John the Baptist has been cast into prison.[13] Leaders should follow this example, and not just be present in a community, but also alert and aware of what is going on around him or her. Jesus was aware that another leader, John, was a spiritual leader sent to prepare the way for Jesus. As John the Baptist was imprisoned, Jesus knew that people would be shaken by this, and that it was time for Jesus to emerge and fulfill ancient prophecies, and John's as well, to preach, teach, save

[13] Matt. 4:12, NIV

and heal the people. All leaders should be led by the Spirit, aware of God's timing, and should not act prematurely.[14]

Second, Jesus traveled to fulfill his mission to bear light on those in darkness.[15] Jesus left home in Nazereth and went to Capernaum. The message for mobilization is that leaders must move out of their comfort zones to reach those in need. Matthew 4:16, NIV states, "the people living in darkness have seen a great light; on those living in the shadow of death a light has dawned." In the SHINE Global Model, leaders are mobilized to bring the light of Jesus to suffering individuals, families and communities devastated by, or forced to cope with, the realities of HIV and AIDS.

Third, Jesus responds by preaching, "Repent: for the kingdom of heaven is at hand."[16] Jesus informed people that God cared about them. Jesus was not silent, but vocal. Leaders today must communicate to constituents the need to acknowledge weaknesses and sins, and adjust lifestyles and behaviors. The kingdom of heaven is still to be preached and prayers for "thy kingdom come" signify faith in a better life when the light, love, peace and wholeness will be established in our daily lives.[17]

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[14] Moses received a sign at the burning bush and a call from God that it was time to help the Israelites. This indicated God's perfect timing, not as a young man when Moses took matters into his own hands. However, it was after the forty years Moses spent in Midian, and the death of the all the men that previously wanted to kill him (Exod. 4:19, NIV). It is also important to note that there was a period of seclusion in the earthy preparation of Jesus. This period was from age twelve, when he is found in the temple, until about age thirty when he appears to be baptized by John. Even after baptism, Jesus spent forty days in the wilderness before embarking on ministry noted in Matt. 4:12-25, NIV.

[15] Matt. 4:12b-16, NIV

[16] Matt. 4:17, KJV

[17] Luke 11:2, KJV

Fourth, Jesus recruited others to join him.[18] The first disciples were called and followed Jesus. Jesus knew the value of training others, so that they could learn from him directly and carry on his work after he was gone. Mobilization projects should include training and recruitment of successors, as well as volunteers and, where possible, paid staff to conduct the day-to-day operations of reaching a target audience and the masses.

Fifth, "And Jesus went about all Galilee, teaching in their synagogues, and preaching the gospel of the kingdom, and healing all manner of sickness and all manner of disease among the people."[19] To further God's will that none would perish and all would be saved, and to address the people's needs, Jesus engaged in a three-fold teaching, preaching and healing ministry. Today's leaders must also ensure that with proclamation and education, there is action by healing occurring in their ministerial contexts.

Sixth, large multitudes followed Jesus throughout the diaspora. "And his fame went throughout all Syria: and they brought him all the sick people . . . and he healed them. And there followed him great multitudes of people from Galilee, and from Decapolis, and from Jerusalem and from Judaea, and from beyond Jordan."[20] When leaders are in place, responding to the ills of the mind, body and spirit, people come and spread the news about what is happening. The importance of the relationship between leaders and those whom they serve is often emphasized in the Christian faith.[21] The result

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[18] Matt. 4:18-22, KJV

[19] Matt. 4:23, KJV

[20] Matt. 4:24-25, KJV

[21] Authors such as Martin Hengel in his *The Charismatic Leader and His Follower* have addressed similar issues.

should be more people following God. When more people are following God, God will be glorified which is the end goal of outreach and inreach efforts in a mobilization project.

Reviewing Biblical Precedents for Mobilization

Table 3 provides a comparison between the biblical precedents set forth in Exodus 3, 4 and Matthew 4 , NIV texts.[22] A pattern is seen for how God responded to the concerns of people or crisis by setting apart or calling a particular person for the task. A period of separation for this primary leader occurs followed by an introduction or reuniting with the primary community to serve. Recruitment of other leaders occurs. Lastly, God often works through chosen leaders to facilitate God's acts of concern to reach large numbers of people. The process results in people following God and God glorified.

Table 3. Summary of Biblical Foundation Examples: How God Calls Leaders to Carryout God's Mission to Respond to the Concerns of People

	EXODUS 3, 4, NIV	**MATTHEW 4:12-25, NIV**
Crisis	Cries of the Israelites while in slavery in Egypt	John the Baptist dies
Primary Leader	Moses	Jesus
Location or Events Immediately Preceding Primary Leaders Earthly Call or Initial Steps to Carryout God's Mission	Lived in Midian after 40 years away from Egypt	Spent 40 days in the wilderness

[22] Other examples of primary leaders who followed a similar flow to the point of recruiting others and a miraculous display that God's power and response to people's concern may be Joshua and Nehemiah.

Table 3. Summary of Biblical Foundation Examples: How God Calls Leaders to Carryout God's Mission to Respond to the Concerns of People		
	EXODUS 3, 4, NIV	**MATTHEW 4:12-25, NIV**
Recruitment and Support of Other Leaders	Aaron The Elders	The First Disciples
God's Action to Respond to People's Concerns	- Led people by a cloud by day and fire by night - Miraculous work that facilitated the Crossing of the Red Sea [Sea of Reeds] - Fought for the Israelites - Deliverance, freedom from slavery in Egypt under Pharaoh's Reign	Jesus does the following: - Goes throughout Galilee - Teaching in their synagogues - Preaching the gospel of the kingdom - Healing every sickness and disease among the people.

Exploring People's Responses to God's Actions: Fear or Faith?

What happens in the days and months after people witness God's direct care for them? Do people keep trusting and believing in God when resources diminish or leaders weaken or are no longer present with them? In each of the examples above, there are indications that people struggle between fear and faith, even when a miraculous display of God's compassion is seen. This is a message for God's leaders that people may quickly become discouraged, yet the leader is not to act in fear but continue to call upon God.

As we look at the children of Israel, not long after they had crossed the Red Sea, only three days, their singing and dancing turned into murmuring for water.[23] In addition, "on the fifteenth day of the second month after they had come out of Egypt," the Israelite

[23] Exod. 15:22-23, NIV

community grumbled because they did not have food.[24] It can be surmised that God's liberation is comprehensive, inclusive of physical and emotional bondage. Human lack of obedience or faith as well as interference may impede complete liberation. The Israelites' freedom from physical bondage is evident, yet it is likely that the Israelites were not free from emotional bondage. Despite crossing over the sea on dry ground (physical deliverance), they displayed emotional bondage to Egypt instead of trusting in God for their provision of food when it seemed in question. In both instances God provided for them. God still heard the pleas of the servants Moses and Aaron who spoke on the people's behalf. Using these servants as messengers and agents, God met the people's needs, and provided them with water,[25] manna and quail.[26]

The New Testament example of Jesus' preaching, teaching and healing the sick perhaps provides the greatest challenge to faith bodies. Will leaders follow the precedent set by Jesus, and remain faithful after his death? The early church continued to heal and deliver the oppressed as described further in the next section, "Historical Foundation." Contemporary Christian leaders should not let any illness, including HIV/AIDS, hinder them from operating in the power and authority of God to meet the needs of those in pain and crisis. Faith not fear is the best mobilization technique for all generations and times.

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[24] Exod. 16:1-3, NIV

[25] Exod. 15:25-27, NIV

[26] Exod. 16:4-35, NIV. Verses eleven through fifteen speak to God's immediate food provision. In the case of the next generation of Israelites who followed Joshua's leadership, there still was evidence of people's lack of trust in God, as evidenced by sin. The city of Jericho had just been captured and devoted to the Lord (Josh. 6:21, NIV). They destroyed every living thing, and burned the whole city except for the silver, gold, bronze and iron items that were to be deposited into the treasury in the Lord's house (Joshua 6:24, NIV). Unfortunately, the Israelites did not have success with their next battle with Ai, for sin had occurred by one man who stole some of the goods to be devoted to the Lord (Josh. 7:1, 7:19-21, NIV). The full account of the discovery of the sin and punishment is found in Josh. 7:10-26, NIV.

Motivation for Action Should Center around Communicating God's Compassion to Others and Glorifying God

Leaders are to remember that God's eye is on the sparrow.[27] Even in the midst of trials, leaders are not to be afraid, for Jesus said,

> I tell you, my friends, do not be afraid of those who kill the body and after that can do no more . . . Fear him who, after the killing of the body, has power to throw you into hell. Yes, fear him. Are not five sparrows sold for two pennies? Yet not one of them is forgotten by God. Indeed the very hairs of your head are numbered. Don't be afraid; you are worth more than many sparrows.

God looks out for persons during hard times and persecution, and cares for each one of us individually and uniquely regardless of our size, race, wealth, socio-economic status, or educational level. God often uses leaders to reach out to the groups of people who need to know that God is concerned about them and who need to experience God's compassion. An ongoing task of God's leaders is to continue to encourage and reassure the people that they must strive to maintain complete faith in God who knows their every condition. William Holladay shares, "It is crucial that those who are oppressed be able to know that God, who marks the sparrow's fall (Matt. 10:29, KJV), hears the cry of the oppressed and comes to their rescue, even if they cannot count on any human intervention."[28]

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[27] Luke 12:4-7, KJV and Matt. 10:28-31, KJV

[28] William L. Holladay, *Long Ago God Spoke: How Christians May Hear the Old Testament Today* (Minneapolis, MN: Fortress Press, 1995), 122.

Indeed, God "knows that you need them (food, clothing, shelter and everything else)."[29] We should heed the Jesus' words when he said,

> Therefore, I tell you, do not worry about your life, what you will eat or drink; or about your body, what you will wear. Is not life more important than food, and the body more important than clothes? Look at the birds in the air; they do not sow or reap or store away in barns, and yet your heavenly father feeds them. Are you not much more valuable than they? . . . For the pagans run after all these things, and your heavenly Father knows that you need them. But seek first his kingdom and his righteousness, and all these things will be given to you as well. Therefore, do not worry about tomorrow, for tomorrow will worry about itself. Each day has enough trouble of its own.[30]

Jesus went to persons who had little, who were considered marginalized or the "least of these," and made them a priority in His ministry. In the book, *Jesus as Healer*, the author Harold Remus presents various biblical and historical accounts supporting this. In one passage, it is stated:

> As in other New Testament gospels of healing stories in Luke show the sick restore in health and thus to society. . . the evangelist includes a number of the healing stories found in Mark and Q. He also includes various of their accounts of Jesus' mingling with social outcasts. However, it is in what scholars have come to call the Lukan Travel Narrative (9:51-18:14)—Jesus' journey to Jerusalem—that we encounter stories found only in Luke (what scholars call "L" material) that, one after another, feature role reversals or Jesus reaching out to embrace persons on the fringes of society or excluded from it.[31]

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[29] Matt. 6:32, NIV

[30] Matt. 6:25-34, NIV

[31] Harold Remus, *Jesus as Healer* (Cambridge, United Kingdom: Cambridge University Press, 1997), 66. This book also provides an overview of scholarly material related to healing related to each of the Gospels, with appropriate references to Old Testament healings by persons such as Elijah and Elisha. Further, he explores the common context of healers in Jesus' day as well as in the early centuries after Jesus' death and resurrection. *Jesus as Healer* is a part of the series "Understanding Jesus Today" edited by Howard Clarke Kee. Other authors have also written extensively on Jesus as healer. For example, Theissen Gard has published works, such as *The Healing Miracle Stories in the Gospel Tradition,* that explore the social, economic and ecological dimensions of healing.

The marginalized in our society today might well consist of those who endure HIV/AIDS. Christian leaders should serve these persons, who may be homeless, addicted to legal and illegal substances, have little or no health insurance, or have no one to love them. By serving the sick and the marginalized, Christians are following Matthew 5:16, KJV, "Let your light so shine before men, that they may see your good works, and glorify your Father which is in heaven." If leaders are mobilizing to aid and assist others in their community, then these leaders should also make effort to ensure that God gets the credit for accomplishments. As stated earlier in this section, assistance to others should result in people helped, introduced to Jesus and reassured of his love, and God being glorified.

Historical Foundation

If a sincere attempt to address the HIV/AIDS pandemic is going to be made, then after building on a biblical foundation, a journey into history is required. The journey is necessary so that a greater understanding might be obtained on how other persons (particularly those of Christian faith) dealt with similar issues. Once the historical foundation is studied, lessons learned may be applied to the current era to foster appropriate responses. This is not to say that everything that occurred in prior times will be specifically relevant to today's struggles to deal with illness and disease. However, reviewing the impact that those struggles had on previous generations may inspire, encourage and provide a foundation for appropriate action today. The caution expressed by the historian David Hackett Fischer is worth noting:

> If people persist in the historical error of applying yesterday's programs to today's problems, we may suddenly run short of tomorrow's possibilities. If we continue to pursue the ideological

> objectives of the nineteenth century in the middle of the twentieth, the prospects for a twenty-first are increasingly dim.[32]

The task to be accomplished in this section is to present a historical foundation for action today. Accounts from the early Christian Church, as well as from the archives and more recent work in the African Methodist Episcopal Church give rise to this component foundation for addressing HIV/AIDS.

The Early Christian Church

In the biblical foundation section, God's response to the people's concerns was discussed with emphasis on how God calls leaders to carryout God's mission by assisting and addressing pain. In particular, spiritual, emotional and physical pain was met with deliverance and healing. Old Testament and New Testament examples of Moses and Jesus demonstrate divinely orchestrated mobilization efforts to address deliverance from oppression and other concerns of their eras. The early Christian church survived epidemics that may have contributed to the spread of Christianity both directly and indirectly.

In the book *Rise of Christianity,* Rodney Stark suggests that two epidemics, one in 165 (probably smallpox) and another in 251 (likely measles) facilitated the deaths of many persons ascribing to pagan religions simultaneous with the growth of Christianity.[33]

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[32] David Hachett Fischer, *Historians' Fallacies: Toward a Logic of Historical Thought* (New York: Harper and Row Publishers, 1970), 317.

[33] Rodney Stark, *The Rise of Christianity: A Sociologist Reconsiders* (Princeton, NJ: Princeton University Press, 1996), 72-94. The chapter "Epidemics, Networks and Conversion" provides cross-references to other texts such as those by William H. McNeill described later. In contrast to Starks account, George Rosen reports three possible diagnoses for the first epidemic, specifically, "exanthematic typhus, bubonic plague, or perhaps smallpox." He offers smallpox as the probable cause for the second epidemic. George Rosen, *A History of Public Health* (Baltimore, MD: The Johns Hopkins University Press, 1993), 20.

The rationales for the increase in Christians that Stark provides include those given in: 1) the writings of Cyprian, bishop of Carthage, which stated that Christianity gave a hope for the future along with a more satisfactory account for why terrible times occurred; 2) an Easter letter of Dionysius, bishop of Alexandria, which declared that Christians' love and charity reflected in social service and community solidarity led to substantially higher survival rates; and 3) changes in social networks that favored more Christian attachments with pagans rather than pagan-pagan ones.[34]

The first epidemic occurred for about fifteen years, during the reign of Marcus Aurelius in about A.D. 165, with estimates that a quarter to a third of population that died.[35] The second epidemic struck the Roman world, resulting in up to 5,000 people dying a day during its peak in Rome, with perhaps higher numbers in rural areas.[36] Historian George Rosen reports that this first epidemic, called Long or Antonine pestilence, lasted from 164 to 180 A.D., while the second epidemic from 251 to 266 A.D was the probable cause of the plague in Cyprian.[37] The growth of Christianity during these epidemic periods has been substantiated in other works which support the premise that epidemics and Christian believers' response to them benefited the new religion. William H. McNeill states:

> Simultaneously, the rise and consolidation of Christianity altered older views fundamentally. One advantage Christians (had) over

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[34] Stark, *Rise of Christianity,* 76-77. Cyprian was bishop of Carthage from 246 until he suffered as a martyr in 258, while Dionysius was bishop of Alexandra from 247 to 264 A.D. Williston Walker, *A History of the Christian Church* (New York: Charles Scribner's Sons, 1934), 70, 105.

[35] Ibid., 73,76.

[36] Ibid., 76-77.

[37] Rosen, *History of Public Health*, 20.

> their pagan contemporaries was that care of the sick, even in the time of pestilence, was for them a recognized religious duty. When all normal services break down, quite elementary nursing will greatly reduce mortality. Simple provision of food and water, for instance, will allow persons who are temporarily too weak to cope for themselves to recover instead of perishing miserably. Moreover, those who survived with the help of such nursing were likely to feel gratitude and a warm sense of solidarity with those who had saved their lives. The effect of disastrous epidemic, therefore, was to strengthen Christian churches at a time when most other institutions were being discredited. Christian writers were well aware of this source of strength, and sometimes boasted of the way in which Christians offered each other mutual help in time of pestilence whereas pagans fled from the sick and heartlessly abandoned them.[38]

The early church's responses to epidemics provide a precedent for modern era Christians' involvement in relief to those suffering due to disease. It also demonstrates the power of their Christian service and witness on others who were not believers.[39] The same Christian caring can be exhibited in contemporary interactions with persons with diseases impacting large portions of the population such as HIV/AIDS. The AME Church has a history of such action.

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[38] William H. McNeill, *Plagues and Peoples* (New York: Anchor Books/Doubleday, 1976), 108.

[39] Stark, *Rise of Christianity,* 83-84. This author records that "a century later, the emperor Julian launched a campaign to institute pagan charities in an effort to match Christians." Julian complained in a letter to the high priest of Galatia in 362 that the pagans needed to equal the virtues of Christians, for recent Christian growth was caused by their 'moral character, even if pretended,' and by their benevolence toward strangers and care for the graves of the dead." Stark further states that Julian wrote to another priest, "I think that when the poor happened to be neglected and overlooked by the priests, the impious Galileans observed this and devoted themselves to benevolence . . . The impious Galileans support not only their poor, but ours as well, everyone can see that our people lack aid from us." This same kind of disdain by some members of society who were embarrassed by their own lack of support of the sick (and the contrasting aid of those disregarded) was seen by Richard Allen and other in the yellow fever epidemic of 1793. This is recorded in the next section.

The AME Church History in Social Action and Health Promotion

Topics covered in this section are in three parts: 1) yellow fever epidemic; 2) health and the AME infrastructure; and the 3) HIV/AIDS Pandemic. Each section provides supporting documentation that validates the AME commitment and historical precedent for large-scale health promotion efforts. There is adequate impetus for an HIV/AIDS mobilization initiative such as this ministry project.

Yellow Fever Epidemic

The AME Church has a longstanding role and history of being proactive in addressing social action causes, including promoting health among members of the community. This history included the eighteenth century acts of Richard Allen, the denomination's founder and first bishop, and other church members and community leaders to address the yellow fever epidemic. Richard Allen and Absalom Jones extended their aid in the epidemic, while maintaining their voice on social justice issues such as abolition or anti-slavery.[40] In 1787, Allen and Jones established the Free African Society, a non-denominational organization and the first black American mutual aid society.[41] Yellow fever attacks began in Philadelphia in 1793, and epidemics continued until almost the end of the nineteenth century—around the time when it was discovered that the mosquito transmitted the disease and a vaccine was prepared by Theiler and

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[40] Henry H. Mitchell, *Black Preaching: The Recovery of a Powerful Art* (Nashville, TN: Abingdon Press, 1990), 46. At one point Allen and Jones defended their roles in a pamphlet that also included Allen's brief anti-slavery tract.

[41] James T. Campbell, *Songs of Zion: The African American Church in the United States and South Africa* (Chapel Hill, NC: The University of North Carolina Press, 1998), 9.

Smith.[42] Philadelphia Mayor Matthew Clarkson saw that the need for volunteers was great (with as many as 100 persons per day dying during the health crisis), so he called on Richard Allen and Absalom Jones to assist.[43] Wealthy residents had left, and the poor and blacks remained subject to the disease. Both men halted church building projects to engage in supportive work.[44]

After noticing the severe extent of the epidemic, with both dying and living persons in each of the twenty houses they visited, Allen and Jones began one of the first "faith-based" health initiatives by systemizing their efforts with Mayor Clarkson.[45] Allen was responsible for organizing crews to remove the dead, while Jones and his team led comfort efforts to assist physicians and nurses.[46] One historian recorded this account of Allen's involvement:

> Sensing an opportunity to win white gratitude and respect, Allen quickly organized medical and burial details, even securing the release of dozens of convicts to assist with the campaign. Through the months of the fever, black men and women dispensed water, succored the sick, and buried the dead, usually without remuneration. Allen himself expended over four hundred pounds to buy caskets and hire gravediggers, less than half of which was ever recovered.[47]

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[42] Rosen, *History of Public Health,* 251, 300-301, 307.

[43] Steve Klots, *Richard Allen: Religious Leader and Social Activist* (New York: Chelsea House Publishers, 1991), 38-42.

[44] Ibid., 37-38. At the time, Richard Allen was leader of the group of black Methodists that would later unite to form Bethel African Methodist Episcopal Church. Absalom Jones was the priest (pastor) of the African Episcopal Church of St. Thomas.

[45] Ibid., 38-39.

[46] Ibid., 39.

[47] Campbell, *Songs of Zion*, 27.

Because of the number and extent of sick persons left behind by fearful family members, Benjamin Rush, M.D. trained Allen and Jones "how to treat the fever victims with medicines and induced bleeding, which was thought to allay the symptoms of the illness."[48] From a 1794 account by Allen and Jones, they remarked, "This has been no small satisfaction for us; for, we think, that when a physician is not attainable, we have been the instruments in the hand of God, for saving lives of some hundreds of our suffering fellow mortals."[49]

Despite collective efforts in Philadelphia, over 5,000 persons died by the end of the yellow fever epidemic in that locale.[50] Mayor Clarkson and Dr. Rush both publicly commended Allen and Jones for their roles that helped make the casualties less severe.[51] At least one person, Matthew Carey, tried to discredit the contributions of Allen, Jones and their teams.[52] The two men responded in a 1794 pamphlet, *A Narrative of the Proceedings of the Black People During the Awful Calamity in Philadelphia.*[53] In Allen

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[48] Klots, *Richard Allen,* 40; George A. Singleton, *The Romance of African Methodism* (Nashville, TN: AMEC Sunday School Union, 1985), 9-11. This book provides a photograph of Dr. Rush with a caption that he was a signer of the Declaration of Independence, celebrated physician, and close friend of Allen. Other "leading whites" who were friends and associates of Allen include Bishop Thomas Coke (United Methodist Church) and Robert Ralston.

[49] William L. Katz, *Eyewitness; The Negro in American History* (New York: Pitman Publishing Corporation, 1971), 59-60.

[50] Klots, *Richard Allen,* 40.

[51] Ibid., 40 and 42.

[52] Ibid., 40. Carey claimed in a public statement that exorbitant amounts were paid for removal of the dead and that there was favoritism for black victims over whites. As referenced in Campbell, *Songs of Zion*, 27, Carey, a leader in Philadelphia's Irish community, reportedly wrote the first history of the yellow fever epidemic (with three quick editions). Campbell reports that African Americans were barely mentioned "except to condemn them for 'profiteering' and 'plundering the dead.' "

[53] Klots, *Richard Allen*, 40-42. Allen and Jones offered these responses: 1) at the time when volunteers were exhausted, fees were used to hire five men to assist with the efforts; 2) proportionally, as many blacks died as whites; and 3) Carey had fled the city and could not have been aware of all that blacks had done, so his account must be based on rumors.

and Jones' written narrative and series of addresses and testimonials they even "offered detailed financial statements" and saluted over 300 blacks who died in the epidemic, sacrificing their lives for humanity.[54]

AME Church founders' had a clear impact on society as they mobilized and acted responsibly to give aid during the yellow fever epidemic. Stronger ties with civic and religious communities (even those they may have previously been at odds with) ensued. As Klots states, "The yellow fever epidemic in Philadelphia enabled the whole community, black and white, to see Allen for what he was: a man of his word and of honor, who found in his faith a call to serve God and humanity. He had responded to people in need, by moving out of the pulpit and into their homes."[55] Receiving official Methodist support after the epidemic, on July 29, 1794, a new church edifice, a converted blacksmith's shop, was moved to Lombard Street, and legacy of African Methodism established even stronger roots.[56]

More than two centuries later, the sentiments of the early church is still echoed in the AME mission statement:

> The Mission of the African Methodist Episcopal Church is to minister to the spiritual, intellectual, physical, emotional and environmental needs of all people by spreading Christ's liberating gospel through word and deed. At every level of the Connection and in every local church, the African Methodist Episcopal Church shall engage in carrying out the spirit of the original Free African Society, out of which the A.M.E. Church evolved: that is, to seek out and save the lost, and serve the needy through a continuing program of (1) preaching the gospel, (2) feeding the hungry, (3) clothing the naked, (4) housing the homeless, (5) cheering the

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[54] Campbell, *Songs of Zion*, 27-28.

[55] Klots, *Richard Allen*, 42.

[56] Ibid.

> fallen, (6) providing jobs for the jobless, (7) administering to the needs of those in prisons, hospitals, nursing homes, asylums and mental institutions, senior citizens' homes; caring for the sick, the shut-in, the mentally and socially disturbed, and (8) encouraging thrift and economic development.[57]

Health and the AME Infrastructure

Early AME Church leaders' appreciation for health concerns and the need for constituents to be informed and act continued to be seen long after the yellow fever epidemic. With the same zeal that AME Church leaders helped spread the Gospel and contributed to the rise of early Black churches, so the mobilization of AME churches to address health issues was based on action and not reflection only. This perspective was even applied to preaching, a force behind mobilization efforts.

The Bishop Benjamin T. Tanner, the 18th elected AME Bishop who was consecrated in 1888 and served 27 years,[58] was quoted in Carter G. Woodson's *The History of the Negro Church*, making statements about the evangelistic spirit that changed the religious spirit in the South:

> While the good Presbyterian parson was writing his discourses, rounding off the sentences, the Methodist itinerant had traveled forty miles with his horse and saddle bags; while the parson was adjusting his spectacles to read his manuscript, the itinerant had given hell and damnation to his unrepentant hearers; while the disciple of Calvin was waiting to have his church completed, the disciple of Wesley took to the woods and made them re-echo with

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[57] The African Methodist Episcopal Church Sunday School Union, *The Doctrine and Discipline of the African Methodist Episcopal Church-2000, Forty-sixth edition* (Nashville, TN: The African Methodist Episcopal Church Sunday School Union, 2001), 13.

[58] The African Methodist Episcopal Church Sunday School Union, *The Doctrine and Discipline of the African Methodist Episcopal Church* (Nashville, TN: The African Methodist Episcopal Church Sunday School Union, 2004), 9.

> the voice of free grace, believing with Bryant, "The groves were God's first temples."[59]

Earlier, Bishop Richard Allen spoke of slaves' support of white preachers of the Gospel during the period of the "the old Revolutionary War between Great Britain and the United States" and gave a reason for affiliation with the Methodists:

> The Methodists were the first people that brought glad tidings to the colored people. I feel thankful that ever I heard a Methodist preach. We are beholden to the Methodists, under God, for the light of the Gospel we enjoy; for all other denominations preached so high-flown that we were not able to comprehend their doctrine. Sure am I that reading sermons will never prove so beneficial to the colored people as spiritual and extempore preaching.[60]

Just as clear, understandable preaching, with related action was emphasized to reach as many persons as possible, so too did AMEs promote ministerial insight in other fields such a health and medicine. Bishop Henry McNeil Turner records specific health matters adopted in the 1888 General Conference that pertained to the training of itinerant ministers. Admissions questions included a section with nine extensive questions on anatomy and physiology to be asked to candidates by the Annual Conference, as well as on spelling (i.e., spell and define ten names of parts of the human body).[61] The early AME Church expected its leaders to be educated with a spiritual and physical

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[59] Sydney E. Ahlstrom, *A Religious History of the American People* (New Haven, CT: Yale University Press, 1972), 701. This quote was referenced from Carter G. Woodson's 1921 book entitled *The History of the Negro Church*, 97-98.

[60] Edward S. Gaustad, ed., *A Documentary History of Religion in America to the Civil War* (Grand Rapids, MI: William B. Eerdmans Publishing Company, 1993), 301-302. The original source was *The Life Experience and Gospel Labors of the Rt. Rev. Richard Allen* (New York: Abingdon Press, 1960 [1793]), 28-30.

[61] Henry McNeil Turner, *The Genius and Theory of Methodist Polity or the Machinery of Methodism* (Nashville, TN: AMEC Sunday School Union, reprinted 1986), 209, 211, 216.

understanding people (as well as other areas defined in the mission statement). This would equip them to address future societal needs.

Many organizational components of the denomination assisted in the health promotion and care of others. Steps were taken to organize the denomination's heath activities. The AME health infrastructure might have begun to be formalized with the Health Commission Project of 1948 for the AME Church.[62] Leonidas H. Berry, M.D. resounded the denomination's development in his own testimony, "Were not my interests in a spiritual life and my medical activities locked into separate compartments of my total life experiences? Should not they be together? Is there not a common ground?"[63] Dr. Berry, a gastroenterologist and former president of the National Medical Society, founded and directed AME First Aid and Health Education Clinics for thirty-two years.[64]

Under Dr. Berry's leadership the AME Church provided needed services and rendered protests against causes such as the refusal to provide medical care. For example, on Sunday, February 15, 1970, Berry organized thirty-two "Flying Black Medics" (as well as local professionals) to aid Ward AME Church in Cairo, Illinois in serving persons refused care at St. Mary's Hospital in Cairo, as well as trying to establish a local clinic for those who traveled as much as twenty-five miles to Paducah, Kentucky to receive emergency treatment. Financial support was received from Bishop H.T. Primm, Fourth

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[62] Leonidas H. Berry, *I Wouldn't Take Nothin' for My Journey: Two Centuries of an Afro-American Minister's Family* (Chicago, IL: Johnson Publishing Company, 1981), 405. The author recounts how his interest in community health led him to engage in the project. He is an AME medical doctor.

[63] Ibid. Berry's statement also reflects the ministry researcher's thoughts as reflected in the preface and Chapter 1, "Ministry Focus."

[64] Ibid. Information in caption in photographs of section on "The Physician and the Public Servant."

Episcopal District, to cover medicine and food, and medical laboratory equipment was loaned. There were 300 persons served by different disciplines, with extensive media coverage. Berry noted the local medical power struggles of holding the event in the church basement as opposed to a hospital and subsequent delay in federal aid due to bureaucracy as the challenges resulting from the endeavor. [65]

One contemporary example of continuation of Dr. Berry's work would be the efforts of the Reverend Kenneth Robinson, M.D., former pastor of Payne Chapel AME Church in Nashville, TN, who persuaded the congregation to hold neighborhood health fairs, with free medical screening and advice given by the church's health professionals.[66] Countless health activities have occurred across the AME Connection, many of which never made it to publication, but are documented in the hearts and lives of clergy and lay persons who passionately serve without recognition at the grassroots level.

The early Health Commission work laid a solid foundation for contemporary efforts. The ministry researcher first learned of the establishment of the Connectional Health Commission in *The Book of Discipline of the African Methodist Episcopal Church-1988*.[67] The ministry researcher has witnessed the development since her involvement in 2000 in collaboration with the Connectional Health Commission's

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[65] Ibid., 410-411.

[66] Eric C. Lincoln and Lawrence H. Mamiya, *The Black Church in the African American Experience* (Durham, NC: Duke University Press, 1990), 387. Dr. Robinson currently serves as pastor of St. Andrews AME Church in Memphis, TN, and has also served as the Tennessee State Health Commissioner.

[67] *The Book of Discipline of the African Methodist Episcopal Church-1988* (Nashville, TN: African Methodist Episcopal Church Sunday School Union, 1988). After reading about the Connectional Health Commission, the ministry researcher had a follow-up conversation with the then presiding prelate of the Second Episcopal District, Bishop Frederick Calhoun James. He shared that the AME Church was committed to the health infrastructure, and noted some of the work that had already occurred in South Carolina (i.e., the Seventh Episcopal District).

executive director, Sister Gwendolyn Williams, as well as since 2005, with the current medical director, the Reverend Miriam Burnett, M.D. In addition, as foundation for this project, a review was conducted of the church law published from 1984-2004, which covers a twenty-four year period through 2008. The key components are found in the following sections.

The Book of Discipline Bicentennial Edition of the African Methodist Episcopal Church – 1984 and the subsequent 1988 book, contain the same information on the Connectional Health Commission.[68] Eight articles are included.[69] Article 1 describes the Commission organization including equal composition of one lay and one ministerial representative from the Episcopal Districts, appointed at the seat of the General Conference by the presiding Bishop of the respective districts. A layman experienced in health matters (i.e., health care and administration) was to be elected to serve as the executive director. The election of a medical director was established as church law in 1992.[70] The organization has stayed much the same over the years. *The Book of Doctrine and Discipline of the African Methodist Episcopal Church - 2004*, is very similar to 1984, except for the specification of Directors of Health of each Episcopal District who comprise the Executive Committee.

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[68] *The Book of Discipline of the African Methodist Episcopal Church-1984* (Nashville, TN: African Methodist Episcopal Church Sunday School Union, 1984); and *The Book of Discipline of the African Methodist Episcopal Church-1988* (Nashville, TN: African Methodist Episcopal Church Sunday School Union, 1988).

[69] *The Book of Discipline – 1984*, 177-179; *The Book of Discipline – 1988,* 178-180, 448.

[70] *The Book of Discipline of the African Methodist Episcopal Church–1992* (Nashville, TN: African Methodist Episcopal Church Sunday School Union, 1992), 460.

The content of the 1992, 1996, 2000 and 2004 *Book(s) of Doctrine and Discipline* contain revised content with only one new section added in 2004.[71] The purpose of the Heath Commission in 1984 and 1988 editions are stated as follows:

> a. The Commission shall serve as a central clearinghouse to supervise and assist in the development of health education programs and activities in local churches.
> b. The Commission shall work out plans and establish a National Resort and Sanatorium where tired and disabled church people may go for rest and recuperation.
> Patients and guests shall be solicited from people of reputable character regardless of church or denominational affiliation. The resort site may be utilized for chautauquas, vacation bible schools, workshops etc.[72]

The 1992 and subsequent church law publications state the following purposes (with no changes in scope, only to minor editorial revisions):

> 1. Help the denomination understand health as an integral part of the faith of the Christian Church;
> 2. Promote the health concerns of our members;
> 3. Advocate access to health care as a right and not a privilege;
> 4. Challenge and work to reform the unjust structure of the health delivery system;
> 5. Seek to make our denomination a healing faith community.
> 6. Collaborate with community organizations to improve the health care system; and
> 7. Encourage each connectional organization to include a health component in its life and work.[73]

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[71] *The Book of Discipline of the African Methodist Episcopal Church–2004* (Nashville, TN: African Methodist Episcopal Church Sunday School Union, 2004),460. The 2004-2008 church law calls for a new component of the Health Commission through the organization of a Health Consortium on the Continent of Africa, the Nations of the Caribbean Islands, South America and Europe.

[72] *The Book of Discipline–1984*, 177-178; *The Book of Discipline–1988*, 178-179.

[73] *The Book of Doctrine and Discipline–2004*, 459.

To carry out the above purposes over the twenty-four year period of AME legislation, Health Commissions at the Annual Conference and local church levels have been established.[74] In this ministry project, provisions for health education and items that directly pertain to the Second Episcopal District deserve separate attention. Health education and promotion is to be accomplished through Connectional Health Commission acts to "publish occasional newsletters, educational guides and pamphlets; sponsor lectures or workshops; screening and other preventive techniques, and health fairs to address critical issues, including AIDS.[75] The inclusion of AIDS as an issue specifically to be addressed was printed as early as the 1992 church law. In addition, the 1984 and 1988 calls for a survey of existing AME health programs and clinics and needs for future expansion to include a health sanatorium on property already owned such as Kittrell, North Carolina (in the Second Episcopal District), Quindaro, Kansas, or new sites like Hot Spring, Arkansas.[76]

A review of the AME health infrastructure would be incomplete without discussion of the ongoing work of the Connectional Women's Missionary Society (WMS) and the AME - Service and Development Agency, Inc. (SADA). Although the ministry researcher will not attempt to discuss all the achievements of these two organizations in health promotion and service, a few areas will be explained to mark the historical significance and contributions of each. Both the WMS and SADA have

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[74] Health Commissions were formerly known as Health Service Guilds and Health Education Guilds in the 1984 and 1988 church law.

[75] *The Book of Doctrine and Discipline–2004*, 461.

[76] *The Book of Discipline–1984*, 178; *The Book of Discipline–1988,* 179.

conducted HIV/AIDS activities described in greater detail in the next section. The WMS, which has been existence for much of the AME Church history, has led health promotion activities to benefit women and families affected by breast cancer, cervical cancer, cardiovascular disease, and diabetes.

Founded 29 years ago, SADA is a voluntary, non-profit organization working to help people help themselves throughout the world by providing essential assistance to those in need through health education and micro-enterprise programs.[77] Examples of SADA's health work include rural and urban outpatient clinics in Haiti, village workshops to on the prevention of sexually transmitted diseases, the importance of breastfeeding and promotion of family planning, as well as efforts to promote safe drinking water.[78]

Overall, more than twenty years of documentation of AME church law regarding health infrastructure and related activities provides sufficient historical precedence for action.

HIV/AIDS Pandemic

As stated in the previous section on "Health and the AME Infrastructure" efforts to address HIV/AIDS have already been undertaken by several AME components. In 2002, Bishop Adam J. Richardson, Jr., while serving in the Nineteenth Episcopal District, led efforts as the president of the Council of Bishops to pass a resolution on HIV/AIDS.[79]

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[77] African Methodist Episcopal Church Service and Development Agency, Inc., *2004 Annual Report* (Washington, DC: AME-SADA).

[78] Ibid.

[79] The resolution copy is included in Appendix H.

It states, "This scourge of our time must be dealt with cogently, compassionately and completely within a holistic framework that does not condemn nor cast judgment on the victim. Our response must inspire hope, faith and love."[80] The resolution recounts the AME Church's involvement in fighting the epidemic since 1985.

HIV/AIDS awareness efforts have also taken place at events surrounding AME General Conferences. For example, in 2000, information was shared at the Christian Men's Freedom Forum and to constituents. In addition, the ministry researcher was able to conduct a workshop on health and HIV/AIDS for the observers and disseminate educational materials.

The AME Episcopal Districts domestically and internationally have made major strides to promote prevention and treatment of HIV and AIDS. Dr. M. Joan Cousin, an Episcopal Supervisor and international HIV/AIDS activist, has been one of the trailblazers in promoting the church's work in this area. Serving as Episcopal Supervisor in the Eleventh Episcopal District (Florida) along with her husband Bishop Philip R. Cousin, Sr. led to the establishment of eleven Centers between 1985 and 1992.[81] In 1993, the Reverend Melvin A. Kennerly, while pastor of Greater Mount Carmel AME Church in Tampa, Florida, completed doctoral work which included establishing an AIDS Care Station and conducting other health promotion activities.[82] In the First Episcopal District (New England, Pennsylvania, Delaware, New York, New Jersey and Bermuda), under the

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[80] Ibid.

[81] Ibid.

[82] Melvin A. Kennerly, "A Study of Selected Health and Wellness Programs and Their Usefulness in Impacting the African American Community" (DMin diss., United Theological Seminary, 1993).

Cousin Episcopal team's leadership, a pastors' retreat occurred, and HIV/AIDS curriculum by the WMS was developed and implemented.

Chapter One described the ministry researcher's firsthand experience in The Eighteenth Episcopal District under the leadership of Bishop William P. Deveaux and Dr. Pam Deveaux. An international HIV/AIDS conference was held in Botswana, and The Joan Cousin Women's Empowerment Centre was established, with foundational support by the First Episcopal District WMS.[83] The next presiding prelate in the Eighteenth, Bishop Vashti Murphy McKenzie, led sustainability and enhancements to the Empowerment Centre and helped establish orphanages for children left behind due to HIV/AIDS. The Deveaux Episcopal team subsequently conducted HIV/AIDS conferences and outreach in the Sixteenth Episcopal District (Suriname-Guyana, Windward Islands, Virgin Islands, Dominican Republic, Haiti, London, Holland, and Jamaica).

Notable awareness efforts have occurred in the two Episcopal Districts that comprise the South Africa (i.e., the Fifteenth and Nineteenth). In the Fifteenth Episcopal District, particularly in the Cape Province in South Africa, the late David van Neel worked to promote HIV/AIDS supportive services through seminars and conferences with social workers, health staff and other AMEs. Bishop Adam J. Richardson, Jr. and Episcopal Supervisor, Mrs. Connie Speights Richardson (an advanced nurse practitioner), held a Mid-Quadrennial HIV/AIDS Convocation in Johannesburg, South Africa (Nineteenth Episcopal District) in December 2002. Mobilization included the design and

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[83] The Council of Bishops' resolution (referenced earlier) also noted that Centers have been operating in Southern Africa since 1998.

conduct of a fifty-seven item HIV/AIDS survey for members and other awareness efforts with technical assistance by faculty and staff of the Florida A & M University in Tallahassee, Florida.[84] The Reverend Fred G. Harrison, former Secretary of Missions of the A.M.E. Church, and his wife, the Reverend Pretty Harrison, also have conducted awareness activities and food distribution to grandparents and others impacted by HIV/AIDS in the Pretoria area of South Africa.

Clergy in the Fifth Episcopal District (that includes seven Annual Conferences representing approximately fourteen states from the Midwest (Missouri) to the West (California). For example, one pastor chaired an HIV Planning Group in Kansas City, Missouri, while another in San Diego, California, wrote a doctoral thesis on HIV interventions in the local church.[85] Under the current leadership of Bishop John R. Bryant and Episcopal Supervisor, the Rev. Cecilia Bryant, training and installation of HIV/AIDS clinic are conducted with the technical assistance of the Reverend Keith E. Andrews, II.

In the Second Episcopal District, for years churches such as Bethel AME Church-Baltimore, Maryland, Bethel AME Church- Greensboro, North Carolina and Allen AME Church in Washington DC have had HIV/AIDS ministries and annual celebration of awareness days such as World AIDS Day. In addition, non-profits affiliated with local churches have conducted ongoing HIV/AIDS services. Again, as mentioned in Chapter One, the Richard Allen Community Development Corporation in Largo, Maryland has

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[84] This survey was made available to the ministry researcher when Bishop and Mrs. Richardson were assigned in 2004 to the Second Episcopal District. Although the survey in this ministry project had occurred in 2003, the instrument from the Nineteenth District will be useful for subsequent work and inspired mobilization efforts of this ministry project.

[85] The Reverend Ralph Crabbe serves in Missouri, and the Rev. Dr. C. Dennis, a United Theological Seminary graduate, serves in California.

rendered primary medical care, case management and transportation services to local HIV positive residents.

An untold number of local churches have supported HIV/AIDS efforts by providing donations, supporting community initiatives such as Meals-on-Wheels programs, and volunteering. In addition, AME clergy and lay leaders have actively participated in HIV/AIDS awareness days such as the Black Church Week of Prayer for the Healing of AIDS sponsored by the Balm in Gilead in New York City. Other church leaders have worked to address HIV/AIDS as a part of their affiliations with ministerial alliances across the United States and abroad. Books have been written to raise awareness such as the work by the Reverend Mankekolo Mahlangu-Ngcobo.[86]

As mentioned above in the section on "Health and the AME Infrastructure," both the WMS and SADA have been engaged in worldwide HIV/AIDS awareness and/or treatment efforts. The Connectional WMS had as its general theme from 2004-2005, "HIV and AIDS: A Global Pandemic and the Village Crisis." The yearbook was produced for worldwide usage in monthly WMS meetings, and included devotionals, study lessons, a list of resources, collaborating models and agencies.[87] In addition, another WMS member wrote a book to assist in creating and sustaining healing ministries

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[86] Mankekolo Mahlangu-Ngcobo, *AIDS in Africa: An African and Prophetic Perspective* (Baltimore, MD: Gateway Press, 2001).

[87] Jamesina M. Evans, Paulette M. Cryer, and Patricia Jones Penn, *HIV and AIDS: A Global Pandemic and the Village Crisis* (Washington DC: Women's Missionary Society, African Methodist Episcopal Church, 2004).

for HIV/AIDS.[88] In Haiti, SADA has organized village workshops on STD prevention, HIV/AIDS preventive care activities with youth and HIV testing and counseling.[89]

In the next section, "Theological Foundation," a framework is presented for assisting leaders (and those served by them) in living faithfully as God helps them to confront and overcome today's obstacles.

Theological Foundation: Understanding Hurdler Theology

Theology is the dynamic process whereby individuals, families and communities come to know God through the successes, failures and challenges along life's journey. Each unique life experience shapes not only the unit(s) of analysis (i.e. the individual, family or community in question), but also the environments in which they live and/or communicate. The ministry researcher's theological perspective can best be described from the perspective of being a hurdler or "hurdler theology."[90] As a former high school and college athlete, the ministry researcher learned much from the experience of being on the track team. Although not currently physically engaged in regular hurdling, the

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[88] Bettye J. Allen, *The HIV/AIDS Perspective For A Healing Ministry* (Washington, DC: AME Connectional Women's Missionary Society). This publication was written by a member of the AME Women's Missionary Society, and disseminated by the connectional headquarters in Washington, DC.

[89] AME-SADA, *2004 Annual Report,* 6.

[90] The hurdler theology included in this chapter has been adapted by the ministry researcher to apply to this ministry project. The ministry researcher originally developed and presented hurdler theology as a part of Systematic I and II courses taught by Dr. John W. Kinney, Dean, Samuel Dewitt Proctor School of Theology at Virginia Union University. It was later elaborated on in a Preaching and Worship II course taught by Dr. James Harris, a professor at the same institution. During the same period, hurdler theology was refined through the deliberations on the spiritual autobiography, context of ministry and synergy for this project in the Doctor of Ministry program at United Theological Seminary.

ministry researcher is spiritually engaged in this exercise on an ongoing basis. Hurdler theology is believed to be an appropriate and acceptable approach to a mobilization ministry project to reach persons infected and affected by HIV/AIDS.

In hurdler theology the understanding of who God is can best be described in light of the challenges faced in one's own path and a discovery of the unique ways in which God helps us address the hurdles in life.[91] With God's assistance, hurdles are transformed from obstacles or challenges into opportunities. Life is the ultimate race, and is comprised of a series of sprints (shorter, quicker races) in which hurdles are viewed as a refreshing opportunity to learn and to grow. The ups and downs along this spiritual journey can be understood through four main components of hurdler theology: 1) preparation for the race; 2) the race; 3) the finish line; and 4) ministerial reflections. Explanations of key terms are provided in Appendix C in Figures C.1 and C.2.

Preparation for the Race

In preparing for a race, a hurdler should begin to identify with the God who wants to see the best performance by each hurdler. In this respect, God is parallel to an owner of a team who either directly or indirectly is involved in every race. The God Owner wants to see humankind succeed, and thus, forever wills and works for the betterment of all. In this church mobilization project, the aim is to address the needs of persons infected and affected by HIV and AIDS. The God Owner working for the betterment of all is what this ministry researcher believes is one of God's top priorities. "All" implies every human,

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[91] Process theology, black theology and liberation theology influenced the ministry researcher's thinking while articulating her own hurdler theology. Related references have been included in the bibliography.

whether rich or poor, privileged or oppressed, regardless of race, gender, ethnicity, nationality and even sexual orientation. God has no limits on who receives care. Consistent with liberation theology, God is the God of the poor and oppressed. Moreover, God cares for the rich and privileged who are also within His care. This ministry researcher sees God as inclusive, caring for the marginalized or those whom some others, including some Christians, would deny or refuse to minister to because of their own biases, lack of knowledge or misunderstandings.

The preparation component of hurdler theology consists of those elements that serve to equip and shape an individual, family or community for all that life may bring. Examples of these elements are: history, God relationship, eternal purpose and God-given talent, as well as health and wholeness.

History describes our early religious exposure. Childhood and adolescent impressions and insights help form the basis of one's spiritual beliefs. History also includes the hurts and hallelujahs, the understandings and misunderstandings, the labor and the rest, and the good and the bad relationships that have occurred during the course of life. This spiritual history may influence what motivates persons to engage in faith-based health promotion and how persons respond to the HIV/AIDS activities by churches. For example, as a preacher's daughter, the ministry researcher has found that exposure and experience with the organized church has influenced her current beliefs and attitudes about God and God's church. Over the teenage years, frustration arose with the apparent hypocrisy and backbiting of some church members and the insensitivity perceived among some clergy. This compelled the ministry researcher to slip away to other churches in search of a way to worship God without all of the preacher's kid (P.K.)

pressures. This experience also helped the ministry researcher to empathize with persons who for various reasons feel isolated or marginalized from the traditional church. Likewise, others may have spiritual histories that motivate them to reach "non-traditional" populations.

God Relationship is essential to one's theological development. A personal relationship with God is critical to the preparation phase of Christian life. It can be equated to a relationship between an athlete (the individual) and the head coach (God). Another important aspect of God relationship in the preparation phase is that one can rely on the blessed assurance that God will not abandon you. Knowing that God will guide, stand with you, and if need be, carry you can be an incentive to let the relationship grow. A head coach also serves as an important confidant who is dependable and seeks the best for you and the team (others in the network or Christian believers). Persons infected and affected by HIV/AIDS, like all others, can be encouraged that God loves and cares for them and seeks to be close to them, regardless of the designation of a disease, disablement or any other factor that may challenge their lives.

Eternal Aim is influenced by the uniqueness and significance of each person's God-given talent. In preparation for race of the Christian life, a person can take comfort in knowing that God has endowed each of us with a unique "goodness" that is essential for our contribution to the witness and praise of humanity towards God. God's eternal aim for our lives does not change due to an illness. God knows the purpose and plan for

each one of us that started at our point of divine creation.[92] In God's sovereignty, with omnipotence, omniscience and omnipresence, God can ensure that the eternal aim is fulfilled in each of our lives despite and in light of obstacles.[93]

Health and Wholeness includes the physical, emotional, mental and spiritual well-being of the runner or preparatory member in the Christian family. Health and wholeness encompasses those factors that enable a person to run the race of life: food (that which nourishes us spiritually and physically); hygiene (that which cleanses and purifies); mental state and attitudes (sound mind); behaviors (those actions that have the power to transform or destroy, the results of discernment); knowledge and understanding (wisdom); and exercises (temple care, acts that enhance the fitness and sustainability of the structures or resources in someone's life).

If the temple (or body, mind and soul) is in poor condition, then it is difficult to enter the race of effective Christian living. A person can be distracted by health concerns, guilt, shame or pain of any form (e.g., physical, emotional, psychological, financial). These factors may impede his or her ability to love a fruitful, fulfilled life. This ministry project advocates addressing HIV/AIDS issues simultaneously, or even before, deeper spiritual issues.[94] Those trained in public health who are also in touch with

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[92] Jer. 1:4-5, 29:11, KJV. The first passage describe God's statement to the child Jeremiah that before he was in his mother's womb, God knew him. The second passage, God ensures a broken people that he will not harm them, and that they should be encouraged that the divine plans are to prosper them and give them hope and a future.

[93] The concept of eternal aim was first introduced to the ministry researcher during a Fall 2001 lecture by Dr. John W. Kinney at Virginia Union University.

[94] In Acts 3:1-16, the man who begged at the temple gate called Beautiful had his physical ailment healed after his encounter with Peter and John as they went up to pray at 3:00 PM. Subsequently, the man "went with them into the temple courts, walking and jumping, and praising God." (Acts 3:8) How many people are looking for healing at the gates of our modern day churches and faith-based organizations? When we address their pain, struggles, and even their physical ailments, we too might find them healed of the heart, body and/or soul, and rejoicing entering the temple with us!

their spiritual side, are in a position to promote health and wholeness, as well as to minister spiritually. God cares about the details in the lives of people and their preparation for the race of life. In order to be effective in the preparation period, the following other topics influence one's readiness for a hurdle race:

- Practice and Commitment – identifying and being willing to work at improving weaknesses while simultaneously building on your strengths
- Dress and Grooming – being equipped with the appropriate attire (e.g., whole armor of God referenced in Ephesians 6) and being as light as possible, clear of excess baggage that will slow you down, cause you to stumble and/or cause you to lose focus
- Pre-race Thinking – taking special care not to infiltrate your mind with reflections on negative attitudes or perspectives of other people or regrets that have arisen due past experiences or failures
- Pre-race Talk – refraining from gossip and meaningless conversation that tears down rather than builds up confidence and love for God and others
- Lane Assignment – recognizing where you are located (e.g., church) and how the designated lanes indicate your speed relative to other runners (opportunities for spiritual growth and development), but more importantly, how you must run the race (i.e., the utilizing lessons learned to date)
- Vision - looking towards the finish line with anticipation and hope

As we adequately prepare ourselves and prepare others, we find ourselves ready to enter the race(s) God has for each of us. In a mobilization project, such as the SHINE Global Model, emphasis is placed on preparing and equipping leaders for the race which is the life experience that involves aiding others by helping them to realize God's love for them through the ministry of presence and action.

The Race

"Let us run with patience the race that is set before us."[95]

The race portion of hurdler theology is primarily the life experiences of the individual, family or community (units of analysis). Someone has entered the race phase when he/she decides to make following the teachings and practices of Jesus Christ a key life priority. Although the commitment may have been made earlier in life, entering the race means there is a resolve to let spiritual growth be foremost in one's life. An individual strives to now make God's purposes chief in his/her life. Inclusive in this pursuit is doing the things on God's priority list, including care for those with various needs, "the least of these."[96] The race consists of the following: 1) strategic points (e.g. the start or blocks, the curves and the final leg); 2) energy level (e.g. reserves, pace and attacking the hurdles), and 3) distractions (e.g. certain thoughts, other people, unrelated goals, sounds, objects and the body state or weaknesses). Below, only strategic points are described. Each provides insight to messages relevant to persons impacted by HIV/AIDS.

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[95] Heb. 12:1, KJV

[96] Matt. 25:37-40, NIV

The Start – Out of the Blocks, Unique Background of A Savior

Identifying with and/or seeking to better understand Jesus initiates one's participation in the race phase of life according to hurdler theology. Jesus was like us, familiar, almost like someone who was a part of the neighborhood, but more. Jesus was more than a local man, he was a Jew and a part of a little understood, often misinterpreted, sometimes persecuted religious group. But Jesus was still more to those in his day (and to us today). He had some qualities, skills and indeed a calling that was uniquely his. Jesus was the much-anticipated Savior or the Messiah. The world awaited his coming as the Redeemer.

The world needed a Savior, someone to serve as a Head Coach directing and guiding individuals, families and communities through lives challenges such as HIV/AIDS. Jesus Christ was someone who could relate to the everyday struggles of people. Thus, Jesus' experiences made him compassionate and empathetic to the needs of the poor, disenfranchised, oppressed and distressed. For every human concern or hurdle, comfort can be obtained from the Savior. Samuel D. Proctor gives insight to the kind of head coach people need to hear preached in the pulpits and experienced in their daily lives:

> How shall they hear? They need to hear that God cared enough to come into our midst in the life of a carpenter's son, among ordinary people in the fullness of time, to share this earthbound abode with us, to taste our existence, our hurt, our pain, and the limitations that we endure, even the chilly hand of death and, then, to open wide the gates of heaven through the marvelous victory of Christ over death and the grave. God is with us in all of the ebb and flow of our days.[97]

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[97] Samuel D. Proctor, *How Shall They Hear?: Effective Preaching for Vital Faith* (Valley Forge, PA: Judson Press, 1992), 31.

Hurdler theology easily agrees with the statement:

> Physically and intellectually and emotionally and spiritually, Jesus lived the same life we all live. He hurt. He played and went to parties. He had to learn. He could be afraid as well as self-confident. He could feel lonely and abandoned by God and his friends. He was one of us—a human being.[98]

The humanity of Jesus is what is emphasized most in hurdler theology; however, the divinity of Jesus is also essential for understanding spiritual growth and maturity. The ability to conquer hurdles has divine implications.

The race is where the action is and where the story of life takes shape. It is through the daily conversations and the proactive and reactive responses that one understands how to stride over hurdles. In narrative theology, Biblical stories and parables give meaning to life. Likewise in hurdler theology, reflecting and sharing the stories and testimonies of conquering life's challenges or hurdles brings freedom to individuals and persons in their network.

The Curves: Ministry of Conquering Hurdles

The ministry of Jesus took off with leaps and bounds. He spent years learning from his parents and those in his hometown. The recorded forty days of temptation in the wilderness were the final rights of passage before he came into his own full-time

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[98] Shirley C. Guthrie, *Christian Doctrine* (Louisville, KY: Westminster John Knox Press, 1994), 240.

ministry.[99] With compassion and love, Jesus sought to address the pain and promise of the weak, tired, left out, and bewildered. In short, he had to conquer hurdles throughout his earthly ministry (see Table 4). As the Good Shepherd, Jesus was willing to search out the lost and those who society "kicked to the curb."[100] Jesus was Counselor to many during his three-year ministry on earth before his resurrection. Through teaching, miracles and faithful devotion to God, Jesus also demonstrated that he was King of kings and Lord of lords. As a son who was one with the great I AM, Jesus was as recorded in John 14:6, KJV, the Way, the Truth and the Life.

Table 4. Hurdles Conquered by Jesus

HURDLE TYPE	JESUS EXAMPLE OF EXPERIENCING HURDLE	WAYS JESUS CONQUERED HURDLES
Satanic Attacks and Temptations	40 days in the wilderness (Matt. 4:1-11, NIV)	- Self-Denial - Reliance on Scripture
Hometown Misunderstandings	"Only in his hometown, among his relatives and in his own house is a prophet without honor." (Mark 6:4, NIV)	- Left town, but not connection with his immediate family - Identity remained Jesus of Nazareth
Struggling Disciples	Peter's Betrayal (Jesus' Prediction in John 13:38, NIV and carried out in John 18:15-27, NIV)	- Unconditional Love - Patience - Forgiveness - Restoration (John 21:15-19, NIV)

[99] Mark 1:12-13, Luke 4:1-13, Matt. 4:1-11. Like Jesus, leaders should realize that preparation for ministry to persons impacted by HIV/AIDS may require a wilderness experience. This may be a time when a leader is faced with his/her own temptations and limitations, and gain a better understanding of how to rely on scripture and faith in the time of adversity. In a mobilization phase of a project, leaders become acquainted with their own level of awareness of HIV/AIDS issues, weaknesses and fears (hurdles), as well as the appropriate strategies to overcome them. This in turn, should make the leaders more empathetic and assists in their service to others.

[100] John 10:11-16, NIV; Luke 15:1-7, NIV

Table 4. Hurdles Conquered by Jesus		
HURDLE TYPE	**JESUS EXAMPLE OF EXPERIENCING HURDLE**	**WAYS JESUS CONQUERED HURDLES**
Overload Syndrome	Jesus heals many until sundown (Luke 4:38-41, NIV)	- Rest (Luke 4:42-44, NIV) - Prayer - Redirection
Religious Oppression and Attempts to Suffocate True Identity	Interaction with the Pharisees, Six Woes (Luke 11:37-54, NIV)	- Be on guard (Matt. 16:11, NIV) - Encouraged disciples to be clear on who he was, Jesus the Christ (Matt. 16:15-16, NIV)

The moral influence theory supports the doctrine of atonement in that "Christ reconciles humanity not by some cosmic battle nor by some legal transaction—both of which would appear to be complete apart from any participation of those on behalf of whom the action is performed—but by showing God's love to us in such a compelling way that we are constrained to respond in wonder and gratitude."[101] Our response to Christ's love for us is indeed a response to his offering of salvation.

Jesus conquered hurdles without sin, for he fully lived what humankind was intended to be, the state before the fall, and prayerfully, the state of those who join Christ at the Second Coming. Furthermore, "Jesus was sinless because, in perfect obedience to God and perfect love for his fellow human beings, he was willing to risk his good name and his 'moral integrity' to be with and for undeserving, unworthy, sinful people."[102] These very characteristics and practices of Jesus make him uniquely qualified to identify with and assist anyone encountering hurdles including receiving a diagnosis of HIV

[101] Daniel L. Migliore, *Faith Seeking Understanding: An Introduction to Christian Theology* (Grand Rapids, MI: William B. Eerdmans Publishing Company, 1994), 153.

[102] Guthrie, *Christian Doctrine*, 241-242.

infection and coping with diseases such as AIDS. Jesus gave his life for friends and helps them to overcome their unique challenges.

The Final Leg – Love, Authority and Eternal Unity with Humankind

> "No, in all these things we are more than conquerors through him who loved us. For I am convinced that neither death nor life, neither angels nor demons, neither the present nor the future, nor any powers, neither height nor depth, nor anything else in all creation, will be able to separate us from the love of God that is in Christ Jesus our Lord."[103]

The ministry of Jesus on earth seemed to end tragically. Nevertheless, it was through the mystery of the cross that the crucified Jesus liberated humanity for all time. Jesus was willing to sacrifice position, fame and power to serve the people, even unto death. Jesus endured humiliation at Calvary that in modern times reminds one of the plights of African Americans and other during HIV/AIDS (see Table 5). Still, that is not the end of the story. The resurrected Jesus captured victory for all who felt rejected and without anyone to care for them. As Hebrews 7 eloquently describes, Jesus was after the order of Melchizedek and was of an eternal order of priests. His work and ministry cannot be terminated. Jesus continues to be prophet, priest and king. Jesus is still reigning glorious and victorious in heaven, but just as importantly, in the lives of men and women across the globe.

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[103] Rom. 8:37-39, NIV

Table 5. Selected Comparisons of Hurdles of Jesus at Calvary and *Persons with HIV/AIDS*		
HURDLES AT CALVARY	**JESUS**	**PERSONS WITH HIV/AIDS**
Public Humiliation	- Unjust public trial - Carrying his burden (cross) through the crowds - Death on a Cross	- Stigma as "untouchables" - Labeling and Breaches of Confidentiality
Suffering and Pain	- Nailed to a Cross - Abandonment by disciples - Government and religious leaders' role in influencing his suffering and death	- High costs and complex medication regimens - Abandonment by family and friends - Government and religious leaders' role in influencing policies and resource allocations that ultimately impact morbidity and mortality rates
Ridicule	- Come down from that cross - He's the King of the Jews	- You got what you deserve - That's the gay or intravenous drug user's disease
Others Seeking Refuge	Thief on the Cross	Infected children, orphans

The Finish Line

> "The race is not to the swift, nor the battle to the strong . . .
> but time and chance happeneth to them all." (Ecclesiastes 9:11, KJV)

The finish line refers to a particular end or goal sought in life. It consists of the reason for living. There is an ultimate, latter day finish line that in hurdler theology refers to the eschatological salvation through Jesus Christ. There are transitional finishes that occur throughout life that might best be considered as milestones along the path of spiritual growth and maturity. Regardless of the type of finish, evaluation is critical. Key evaluation indicators are: personal, family and/or community reaction; head coach feedback (written or inspired); and debriefings.

Personal, Family and/or Community Reaction

It is inevitable that direct or indirect reactions of others will occur as one completes the race. The hurdler must be careful to allow constructive criticism time to do its work. Reactions may happen immediately or over time, but they are extremely valuable regardless of when they occur. The "drops of experience" at the conclusion of a race may impact all future transitional races.

Head Coach or Owner Feedback

At the conclusion of a race, a hurdler should desire to have the God Owner or Jesus Christ, the Head Coach, say, "Well done, good and faithful servant! You have been faithful with a few things; I will put you in charge of many things. Come and share your master's happiness!"[104] This sums up the response for contemporary and future times. It applied to the faithful servants in this parable of talents (Matt. 25:14-30, NIV), and likewise applies to those who faithfully finish the race(s) in the Christian life. Today, it may also apply to those who, despite challenges, are able to persevere and use the resources that were given to make a difference in the world. An arena where this service and good stewardship may be applied is with those suffering due to HIV/AIDS.

Debriefings with Teammates and Others

Discussions with fellow hurdlers and teammates should occur once a race is completed. In the African American church tradition, testimonies have served as a means for sharing and celebrating the conquering of life's hurdles. One hurdler's

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[104] Matt. 25:23, NIV

accomplishment impacts an entire team. How you run a race may encourage or discourage another teammate. Pastors and other spiritual advisors or "Assistant Coaches" to the Head Coach, Jesus Christ, provide useful insights. Debriefings or one-on-one discussions or counseling sessions with these persons often prove helpful.

In a mobilization project to address HIV/AIDS, it is imperative that leaders and participants have hope. Hope is vital for living each day, and for looking forward to the days to come. Leaders must believe that effective ministries to those impacted by HIV/AIDS can be developed, persons will be helped, lives will be changed, and the teachings of Jesus will be implemented with joy. Others infected or affected by HIV/AIDS can be inspired to maintain hope that: the spread of the disease can be reduced or eliminated, a cure might come, medical treatment will be available and enhanced, relationships can be strengthened and rebuilt, new healthy friendships can develop, stigmas and stereotypes can become null and void. These are all ingredients of a successful finish in human lives.

Ministerial Reflections

> "He (God) giveth power to the faint; and to them that have no might he increaseth strength. Even the youths shall faint and be weary, and the young men shall utterly fall: But they that wait upon the Lord shall renew their strength; they shall mount up with wings as eagles; they shall run, and not be weary; and they shall walk and not faint."[105]

Both clergy and laypersons may experience ministerial reflections. These reflections allow the unit(s) of analysis to ponder lessons learned, race challenges, and future direction. Each transitional finish sparks new opportunities to review and begin a

[105] Isa. 40:29-31, KJV

new race until the ultimate finish line is crossed at the end of life, Second Coming or Judgment Day. Ministerial reflections allow a person to see the ways in which running the race helps one and others.

Concern for others arises during ministerial reflection. With the same passion that is evident for the poor in liberation theology, hurdler theology stresses aid to all those persons going through challenges. These challenges may be emotional, spiritual, physical or financial. A person's socioeconomic, racial or ethnic background cannot shield him/her from the pressures and concerns in life. In fact, the unit of analysis is never just the individual, for the family and community are impacted. Ministerial reflections call for attention to the entire network of people who are affected directly or indirectly by how hurdles are dealt with on an ongoing basis.

As the previously referenced passage in Matthew 25 suggests, a reward from the King is received when we do good for others such as visiting persons who are sick and in prison and providing food, drink and shelter. New support ministries and more effective mentoring or discipling of other hurdlers should develop. This helps individuals and the entire team. Development of stronger relationships between leaders and world missions may result as reflections give rise to increased ministerial activities and services.

The SHINE Global Model calls for continuous ministerial reflection. As clergy and lay leaders are mobilized to address HIV/AIDS, they must reflect on their own beliefs, strengths and weakness, and motive for ministry. Leaders must consider biblical, historical, theological and ethical foundations. Ethical considerations are discussed further in the next section.

Ethical Foundation

It is appropriate and necessary to address ethical concerns as yet another foundation for action of an Episcopal-district wide HIV/AIDS awareness project. Although the biblical, historical and theological foundations present information that might fully justify such an endeavor, the ethics behind action is ground for careful examination of areas that may be stumbling blocks among some leaders and congregants. The ministry researcher recounts several basic premises that shape the ethical foundation for this project: 1) HIV/AIDS should be treated as a public health concern to be addressed; 2) it is unnecessary for leadership to know the means by which an individual has contracted HIV/AIDS in order to exhibit caring Christian acts; and 3) it is unethical to fail to assist those infected or affected by HIV/AIDS in some manner whether by direct or indirect interventions.

HIV/AIDS Is A Public Health Concern

This ministry research project acknowledges and strongly supports the exploration and understanding spiritual components that should be addressed when promoting health and wholeness. However, religious or faith factors may not be the first, or indeed the only component, that must be considered. The urgency of HIV/AIDS requires that interventions begin with public health measures to inform, educate and indeed prevent the spread of the disease, as well as to treat as medical knowledge and technological advances dictate. Dialogue on the spiritual components can wait if it impedes immediate action for the benefit of suffering people. Therefore, the ministry

researcher favors a public health approach over a theological debate. Jesus embraced a tri-fold ministry of teaching, preaching, and healing every disease and sickness.[106]

Many in the religious community have stumbled and delayed steps to address the HIV/AIDS crisis on supposed moral grounds. Early in the pandemic, and even today, some consider the illness to be a modern-day divine judgment. This disease is considered by some to be like leprosy, a judgment, a sin and a just cause for treating a person as an outcast. However, the New Testament demonstrates through cleansing rituals, and indeed Jesus' healing, the sting of judgment was placed less on the persons with the disease, and more on those who do nothing to help or assist them.[107]

Daniel Fountain, M.D., a medical missionary, points out examples of grounds Christians sometimes give for their inactivity, and gives his own retort:

> First, much prejudice exists in church circles against persons infected with HIV . . . when HIV can infect anyone . . . Second, HIV infection is presumed by many Christians to be a curse from God for immoral behavior, and thus, 'We should not interfere in what God is doing to infected persons.' There is no biblical justification for this. Third, there is much fear among Christian leaders . . . fear of being contaminated through casual contact . . . in spite of much information showing that the fear is unfounded. There is fear of associating with people presumed to be immoral . . . fear of death and dying and of facing unanswerable questions and irresolvable problems . . .
>
> Many churches have become tolerant of what the Bible describes as immoral behavior. There are church leaders, even pastors, who are involved in the kind of sexual behavior that can expose persons to HIV. They are, therefore, uncomfortable in educating against these behaviors. Some pastors fear preaching about biblical morality because many in their congregations might leave.

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[106] Matt. 4:23, NIV

[107] See the next section which explains why it is unethical not to act to assist persons with HIV/AIDS.

> Many church leaders assume wrongly that HIV infection is simply a medical problem, and is therefore not the concern of the church. They fail to recognize the social, moral, psychological, and spiritual aspects of the infection.[108]

Fountain's summary of Christian concerns has been echoed throughout the HIV/AIDS pandemic. Likewise, many, including this ministry researcher, agree with his offering of strategies to overcome reluctance through increasing educational efforts and learning to care for those with HIV infection and AIDS.[109] This ministry researcher urges that in this project, prevention and control of HIV/AIDS should be paralleled to other diseases. How a person acquires a disease such as cancer, heart disease, and indeed sexually transmitted diseases such as HIV/AIDS and herpes, is important only in as much as an individual, community or institution is prepared to help a person out of his or her condition or to better cope.

Acknowledgment that HIV/AIDS exists and is endangering precious lives is sufficient cause to act, even before the "whys" and "hows" are identified. Faith communities must be prepared to deal with and heal painful situations and diseases, as well as stand ready to provide guidance and support as persons hear the Gospel and change behaviors and ideas which may conflict with spiritual growth and maturity. This subject is covered further in the next section.

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[108] Daniel E. Fountain, "Ethical Issues in the HIV Epidemic," *Ethical Issues in Health-Related Missions* (Deerfield, IL: The Center for Bioethics and Human Dignity, n.d.), 49-50.

[109] Ibid., 50.

Knowing the Details of How A Person Contracted HIV/AIDS Is Unnecessary for Christian Action

When discussing a health area such as HIV/AIDS, the inclination may be to ask, "How was it contracted?" This ministry researcher believes that an answer to this question need not be a prerequisite for action by church leadership to address the pain of persons impacted by HIV/AIDS. Knowing whether a person(s) was infected with HIV due to sexual intercourse (by any method), intravenous drug use, blood transfusion, or mother-to-child transmission should not be dictators or determinants of the expressions of compassion by persons of Christian faith.[110] Furthermore, in a mobilization project, emphasis must not be on why a person seeks to become involved in prevention and/or care initiatives. Persons may seek to participate in an HIV/AIDS project for a variety of reasons including, but not limited, to the following: the infection or death of a loved one, personal infection, general desire to help those in need, urge to share the love and compassion of Jesus Christ with persons who may feel alienated from God or other Christians.

Caring should proceed questioning. Questioning should be limited to areas that the can lead to the edification and growth of the persons in need of spiritual, emotional, physical or financial support. Even such questioning must be done confidentially, with respect for the individuals involved. From an ethical standpoint, knowing how the HIV/AIDS virus was contracted or why a person seeks to participate in a mobilization project may violate the rights of the individuals and families and may even cause the listener to struggle with guilt or temptations.

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[110] The importance of Christian compassion was discussed earlier in this chapter in the Biblical section, "Motivation for Action Should Center around Communicating God's Compassion to Others and Glorifying God."

Examples of the dangers of spiritual and health leaders who have exceeded boundaries in offering support can be found in historical and contemporary sources.[111] Professional abuse by health and religious workers, inappropriate touching and discussions as well as breach of confidentiality through open prayer requests, sermons, testimonials, presentations and case studies by sharing detailed descriptions of persons impacted.[112] Case studies are available to facilitate discussion on how to respond confidentially to clients with HIV/AIDS.[113]

It Is Unethical to Fail to Assist Those Infected and Affected by HIV/AIDS

To come to the aid of persons who are affect by HIV/AIDS is a Christian and indeed, human imperative. The societal principle, "do no harm" and biblical teachings like, "Love your neighbor as yourself"[114] support this imperative. In the African American community, the danger of not being treated for an illness has been experienced

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[111] Philip J. Wogaman, *Christian Ethics: A Historical Introduction* (Louisville, KY: Westminster/John Knox Press, 1993), 58-59. In this book, Wogaman discusses the human sexuality of by referencing Saint Augustine, a Christian thinker who lived 354-430 AD. Augustine's autobiography, *Confessions,* reveals his own strong sexual drives and living with concubines and having a child out of wedlock. Wogaman states on page 59 that, "Augustine, like Paul before him, elected to maintain a life of the strictest celibacy for himself, and the net effect of his teaching is to suggest that that is morally the higher course for those for whom it is possible."

Contemporary ethical issues relating to spirituality may be found in sources such as: Stephen E. Lammers and Allen Verhey, *On Moral Medicine: Theological Perspectives in Medical Ethics* (Grand Rapids, MI: William B. Eerdmans Publishing Company, 1987).

[112] For additional sources on the subject see Marie M. Fortune, and James N. Poling, *Sexual Abuse by Clergy: A Crisis for the Church* (Decatur, GA: Journal of Pastoral Care Publications, Inc., 1994), JPCP Monograph No. 6; Ruth T. Barnhouse, *Clergy and the Sexual Revolution* (Washington, DC: The Alban Institute, Inc., 1987); and Chiniquy, *The Priest, The Woman and The Confessional* (Chino, CA: Chick Publications, n.d.). This latter historic book did not list a copyright date or the author's first name; however, it does include references to the tradition and background surrounding the seemingly controversial content.

[113] Barbara Herlihy, and Gerald Corey, eds., *ACA Ethical Standards Casebook* (Alexandria, VA: American Counseling Association, 1996), 209-213.

[114] Luke 10:27, NIV

first-hand in the historic Tuskegee Syphilis Experiment. The ethical concerns from an Afro-centric perspective were presented and critiqued by Marimba Ani in a section of his book that describes the syphilis study and cautions that urgent attention is required with HIV/AIDS.[115] From 1932 to 1972, the Public Health Service of the United States Government authorized research on how the men with the severest form of syphilis, tertiary stage, progress in the disease and the complications that result. This government supported forty-year case-control study of African American men from Macon County, Alabama was conducted with 600 men (i.e., 399 with syphilis and 201 controls without the disease).[116]

Men in the "Tuskegee Experiment or Study" were observed, reportedly not told they had the disease, but vaguely were informed that they had "bad blood." In addition, these African American men were not offered treatment. Many of these men died from related complications such as tumors, bone deterioration, and syphilis attacks to the cardiovascular and central nervous system. This suffering occurred in spite of the advancements in medicine, such as treatment by penicillin, and interference with the

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[115] Marimba Ani, *Yurugu: An African-centered Critique of European Cultural Thought and Behavior* (Trenton, NJ: African World Press, 1994), 433-446.

[116] Ibid., 433. The author notes that the name "Tuskegee" was given to the study since it was the name of the county seat of Macon County, Alabama and well-known educational institute founded by Booker T. Washington. Another relevant statement occurs on page 121 in the 1991 book, *Think and Grow Rich A Black Choice* by Dennis Kimbro and Napoleon Hill. The reference in the chapter, "Faith: A Prerequisite to Power" records Booker T. Washington's statement urging black Americans to "start where you are with you have, knowing that what you have is plenty enough." Certainly in the current era, this statement applies to African American communities' ability to address HIV/AIDS using its faith in God and the collective resources (e.g. individuals, families, churches, businesses). This subject is addressed earlier in this chapter with biblical mandates for action, as well as at the conclusion of this section on the high Christian ethical standard.

treatment attempts of others were evident. Although the CDC initially denied this, a physician involved in 1932 came forward to dispute this, stating that "neither the attending interns nor the subjects knew what the study involved."[117]

Media attention helped unveil the tragedy. A reporter in 1972, Harry Reasoner, stated that humans were used "as laboratory animals in a long and inefficient study of how long it takes syphilis to kill someone."[118] Many others before and since Reasoner and Marimba Ani have documented the short-and long-term impact on African Americans participation in the health care system.[119]

Ani contends that the syphilis study is a wake up call, and that similar trends with HIV/AIDS must be examined and addressed. Examples of parallels include: distortion of the truth of the early years of the epidemic, origin theories, government denial of the nature of the disease and the diversity of persons affected, research on vulnerable persons in Africa and the United States, and of course, failure to aggressively explore cures and make available suitable treatment of the disease.[120] He argues that making a "pernicious association of people of African descent with sexual promiscuity established the

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[117] Ibid., 435. Note the official name of the agency today is the Centers for Disease Control and Prevention.

[118] Ibid., 436. Originally, this reference was taken from James H. Jones' book (see next footnote below).

[119] One historic commentary is the book by James H. Jones often referenced in health and cultural studies. James H. Jones, *Bad Blood: The Tuskegee Syphilis Experiment* (New York: The Free Press, 1981).

[120] It is interesting that a formal apology by the United States government for the travesty of the Tuskegee Syphilis Study occurred in the 1990s, a period when the HIV/AIDS epidemic was increasing to other communities beyond predominantly White, gay men first identified with the disease in the United States in the1980s.

atmosphere in which the Tuskegee Experiment could be tolerated."[121] Furthermore, Ani rejects deceptive incentives to entice the poor such as meals, clinic services, apparent prestige of inclusion in a study and even employees of the same race who may be used to present and/or sustain questionable research, however unknowingly.

Ani cites examples which some might interpret as a part of a conspiracy theory, which foster a passive approach to addressing the spread of HIV/AIDS, that in turn will lead to more deaths. Many other have also made claims on the origin of HIV/AIDS that have caught public attention.[122] Thus, there is a call for more concerned and vocal minority media, researchers and physicians. In the twenty-first century, citizens and public officials must be proactive in ensuring that federal budget allocations are at sufficient levels to address the epidemic.[123]

If the public health community is held to an ethical standard to treat ailments and not just observe them, how much more are the followers of Jesus Christ. Indeed, Christians are held to an ever higher standard, and are mandated to act. A clear example of this is in Jesus' parable of the Good Samaritan.[124] Initially, an expert of the law (a religious leader) asked Jesus, "What must I do to inherit eternal life?"[125] Jesus replied by

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[121] Ibid., 436.

[122] Edward Hooper, *The River: A Journey to the Source of HIV and AIDS* (Boston, MA: Little, Brown and Company, 1999).

[123] Just as the Congressional Black Caucus of the United States issued a "State of Emergency" in late 1990s, in February 2007, a meeting was held in CDC once again state the alarming impact of HIV/AIDS in the African American community. (See also Chapter One, section on "HIV/AIDS Morbidity and Mortality."

[124] Luke 10:25-37, NIV

[125] Luke 10:25, NIV

asking the man what is written in the law and how the man reads it.[126] The man answered: " 'Love the Lord your God with all your heart and with all your soul and with all your strength and with all your mind', and, 'Love your neighbor as yourself.' "[127] Jesus shared that the man answered correctly and said to him, "Do this and you will live."[128] By this statement, Jesus attaches eternal life to how we treat one another. Jesus further clarifies the need for action to aid one another, when through the Good Samaritan parable, Jesus addressed the man's attempt to justify himself when the man asked who his neighbor was.

In the parable of the Good Samaritan, a man was beaten, stripped and robbed while traveling from Jericho to Jerusalem. Left for dead, Jesus describes the response of three persons who witness the event: 1) a priest who passes by on the other side of the road; 2) a Levite who also passes by on the other side; and 3) a Samaritan man who took pity and action to care for the victim's wounds, lodging and comfort. Jesus then asked the expert of the law, who the robbed man's neighbor was? "The expert of the law replied, 'The one who had mercy on him.' Jesus told him, "Go and do like wise."[129]

Twice Jesus exhorts and instructs followers to act in a loving, merciful manner in dealings with others. Christians today, should see the pain along their daily roads of human existence, and stop to make a difference by offering tangible support and expressions of compassion. As a perfect example, Jesus addressed the needs of those who were suffering during his earthly ministry. Jesus healed those who had leprosy and those

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[126] Luke 10:26, NIV

[127] Luke 10:27, NIV

[128] Luke 10:28, NIV

[129] Luke 10:37, NIV

who were demon-possessed. He gave life-saving instruction to those whose sexual behaviors and lifestyles were along a path of destruction. Direct interventions (hands on, direct service), as well as indirect means (encouragement of others, recruitment and training of leaders)

were utilized.[130] This may also be viewed in traditional missionary terms of those who "go" to the field and those who "send" by providing prayer, finances or other support for those who go to directly serve in various locales.[131]

A health, faith and ethics article by Robert Wuthnow raises critical issues for action such as: donating to charities, motivating volunteers, addressing unmet social needs, avoiding the excesses of individualism, rebuilding a sense of community and meeting the challenges.[132] Building community may still be a struggle for some as Cathy J. Cohen challenges the Black church and civic organizations in a chapter in her book entitled, "Willing to Serve, but Not to Lead."[133] After citing the work national groups based in New York such as the Black Leadership Commission on AIDS (BLCA) and the

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[130] Numerous examples are found in both the Old and New Testaments. Some of these have been covered in the biblical foundation for action earlier in this chapter. Passages such as Matthew 25:34-46, NIV which also link eternal life to providing for those who are hungry and thirsty, strangers, persons in need of clothing, the sick and those in prison. Jesus closes this pericope in Matthew 25: 45-46, NIV with how the King will address those who saw need and did not act. "He will reply, 'I tell you the truth, whatever you did not do for one of the least of these, you did not do for me.' " "Then they will go away to eternal punishment, but the righteous to eternal life."

Another example of Jesus' direct intervention includes his interaction with the Samaritan woman (John 4:1-30, KJV) and the woman caught in adultery (John 8:1-11, KJV).

[131] Other persons and their related works support literature, literacy, radio, television and the internet to advance assistance options. One example of such a supporter is Thomas Hale, a medical doctor/surgeon and theologian whom the ministry researcher met and continues to follow his missions work in Nepal and the United States. Thomas Hale, *On Being A Missionary* (Pasadena, CA: William Carey Library, 1995).

[132] Robert Wuthnow, "Giving and Caring in the 1990s" *Second Opinion 18(3): 69-80, January 1993* (Chicago, IL: The Park Ridge Center for the Study of Health, Faith and Ethics.)

[133] Cathy J. Cohen, *The Boundaries of Blackness: AIDS and the Breakdown of Black Politics* (Chicago, IL: The University of Chicago Press, 1999), 250-292.

Balm in Gilead, Cohen points out a hypothesis by Tracey Gardner-Wright, that these groups may have had success in reaching the black church in part because they were led by heterosexual women, Debra Frazier Howe and Pernessa Seale respectively.[134] Cohen notes that black gay activists have established their own religious institutions such as the Unity Fellowship in New York, San Francisco, Atlanta, Washington DC and Los Angeles.[135] Establishing these institutions still does not relieve the traditional black churches of the responsibility to be engaged in fighting HIV/AIDS and in confronting issues that thwart their involvement. People need to know how to treat HIV and AIDS, and those infected need to have access to treatment. There is a mandate for action.

The biblical, historical, theological and ethical foundations for action have been covered in this chapter. The researcher has provided the overall framework for action based on the ministry focus, literature and theoretical foundations. The following chapters concentrate on the ministry project, the *SHINE Global Model for Second Episcopal District Mobilization for HIV/AIDS Prevention and Care Efforts Using Government and Faith-based Initiatives.*

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[134] Ibid., 283.

[135] Ibid., 288.

CHAPTER FOUR

METHODOLOGY

Action research methodology[1] will be employed for the collection of data in the Second Episcopal District of the African Methodist Episcopal (AME) Church, which includes the states of Maryland, Virginia, North Carolina and the District of Columbia. The Second Episcopal District is comprised of five Annual Conferences: Baltimore, Washington DC, Virginia, North Carolina and Western North Carolina. The ministry researcher is a member of the Washington Annual Conference of the Second Episcopal District, and seeks to have a positive impact on the lives of those within the district, as well as in the communities served by its constituents. This is consistent with the following statement: "Action researchers are intent on describing, interpreting and explaining events (enquiry) while they seek to change them (action) for the better (purpose)."[2] Action research, also referred to as practitioner-led or practitioner-based research,[3] can be adequately defined by the following statement:

> (Action Research) AR is social research carried out by a team encompassing a professional action researcher and members of an organization or community seeking to improve their situation. AR promotes broad participation in the research process and supports

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[1] Jean McNiff, Pamela Lomax, and Jack Whitehead, *You and Your Action Research Project* (London: Routledge, 1996); Jean McNiff and Jack Whitehead, *Action Research: Principles and Practice* (London: Routledge, 2002), 15; Davydd J. Greenwood and Morten Levin, *Introduction to Action Research: Social Research for Social Change* (Thousand Oaks, CA: SAGE Publications, 1998), 4.

[2] McNiff, Lomax and Whitehead, *You and Your Action Research Project*, 13.

[3] McNiff and Whitehead, *Action Research*, 15.

> action leading to a more just or satisfying situation for the stakeholders.
>
> Together, the professional researcher and the stakeholders define the problems to be examined, cogenerate relevant knowledge about them, learn and execute social research techniques, take actions, and interpret the results of actions based on what they have learned.[4]

In this project, "stakeholders" refers to the Professional and Context Associates who collaborate with the researcher. Professional Associates will be up to three persons who will provide technical assistance during the project, primarily providing feedback to the researcher on the design, implementation and evaluation of the project. These persons are required to hold a terminal degree as required by the seminary. In addition, multiple Context Associates (including both clergy and lay leaders) will assist the researcher by sharing input on planning and implementation, including ongoing perspectives on the feasibility and sustainability of the project. Collaboration with the various associates will assist the project in meeting the needs of constituents in the Second Episcopal District of the AME Church.

Action research allows the researcher to use methodology that is "both context specific and linked closely with the skills, background, and interests of the practitioner."[5] The methodology will also be mixed, using qualitative and quantitative methods. The qualitative methodology will use in-depth interviews and participant observations, while the quantitative methodology will incorporate the use of surveys to collect data.

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[4] Greenwood and Levin, *Introduction to Action Research,* 4.

[5] Ibid., xi.

Research Questions for the Project

Three key research questions will guide the interventions for this project.

1. As related to their annual conference affiliation, what is the extent that members have:
    a. Attended a health and/or HIV/AIDS presentation or workshop at selected AME Meetings;
    b. Ever attended an HIV/AIDS presentation or workshop (in any setting and when it occurred); and
    c. Shared or heard a clergyperson discuss HIV/AIDS with the church congregation?
2. What is the likelihood that members would support an HIV/AIDS church-based awareness project among African Americans and/or in Southern Africa, as related to their annual conference affiliation?
3. What is the perceived extent of readiness, opportunities and challenges of the Second Episcopal District to address HIV/AIDS and related issues, as determined by in-depth interviews with selected leadership including: the Bishop, Episcopal Supervisor, Presiding Elders and Pastors?

Hypotheses

Hypothesis One: There will be greater attendance at HIV/AIDS presentations and workshops at the local church level than at the district conference and Second Episcopal District levels of the AME Church.

Hypothesis Two: There will be no significant differences between annual conferences in the likelihood that respondents will: 1) support an HIV/AIDS church-based awareness project among African Americans and 2) support an HIV/AIDS project focused on Southern Africa.

Hypothesis Three: The Second Episcopal District will be perceived by church leaders in in-depth interviews to be ready to address HIV/AIDS issues, given adequate training and other support services.

Intervention (Description of Ministry Project)

The *Spiritual Growth and Maturity, Health and Wholeness, Insight, Networking, and Empowerment (SHINE) Global Model for Second Episcopal District Mobilization for HIV/AIDS Prevention and Care Efforts Using Government and Faith-based Initiatives* will provide the framework for the project. The SHINE Global Model was developed by the ministry researcher as a result of lessons learned while serving the AME Church in Southern Africa as well as in the Second Episcopal District.[6] The SHINE acronym is summarized as follows:

1. **S**piritual Growth and Maturity – Those elements that contribute to increasing one's understanding of belief in God, as well as strengthening one's personal and corporate relationships with God;
2. **H**ealth and Wholeness – Prevention and care activities that promote physical, spiritual, financial and mental health addressing these areas either collectively or individually;

[6] See Chapter One, "Spiritual Pilgrimage."

3. Insight – Use of resources in education and technology to develop innovative strategies to increase one's literacy and understanding of HIV/AIDS;
4. Networking – Collaboration with individuals in the public and private sector, as well as institutions at the federal, regional, state and local levels; and
5. Empowerment – Interventions that enhance sustainability of health and wholeness activities, particularly infrastructure enhancement and intergenerational strategies to be incorporated into overall church life.

The above SHINE focal areas are key considerations during the four model phases: 1) Mobilization; 2) Implementation; 3) Evaluation and Sustainability; 4) Replication and Expansion of project in other locations and to address other health concerns (see Figure 2). Phase I will be the focus of this doctoral project. Phase I (Mobilization) of the SHINE Global Model will be applied to this project in order to:

a) Provide a conceptual framework which guides preparation of the Episcopal District to address HIV/AIDS; and
b) Increase understanding of current HIV/AIDS awareness and readiness levels.

It is not unusual for other projects, particularly quantitative studies, to use a conceptual framework that is derived from other theories or models or insights of the researcher. For example, a church-based campaign for prostate cancer interventions used the Health Belief Model and Locus of Control theory.[7] The two theories together provided the basis for the research in the development of the Clarke-Tasker Conceptual

[7] Veronica A. Clarke-Tasker, "Relationship of African Americans' Socioeconomic Status to Their Perceptions of Cancer" (Ph.D. diss., University of Maryland, 1996), 11.

Model on the relationship of socioeconomic status to African American's perception of cancer.[8] Theoretical and/or conceptual models guide research studies.

[8] Ibid.

Figure 2. Summary of Phases of the SHINE Global Model

MOBILIZATION (Phase I)

- Identification of Ministry Focus/Problem
- Identification of Primary Leaders
- Assessment of Constituents' Knowledge, Attitudes, Beliefs and Roles for Ministry Focus
- Recruitment and Support of Other Leaders (Call to Action)
- Recognition of God's Action to Respond to the People's Concerns (e.g., opportunities, resources, answers to prayer requests, deliverance)
- Implications and Recommendations to Enhance Mobilization Efforts (e.g., SHINE Global Model applications, capacity building, ministerial education and practice, further research)

IMPLEMENTATION (Phase II)

- Create Appropriate Intervention(s) Consistent with Ministry Focus and Phase I Findings
- Focus intervention(s) on SHINE Focal Areas (e.g., Spiritual Growth and Maturity, Health and Wholeness, Insight, Networking and Empowerment)
- Establish Evaluation Criteria and Begin Ongoing Evaluation
- Recruit and Train Volunteers and/or Paid Personnel
- Implement Activities to Address Ministry Focus

EVALUATION AND SUSTAINABILITY (Phase III)

- Intensify Evaluation Efforts (Using Qualitative and Quantitative Methods) to Capture Lessons Learned, Outcomes, and Overall Project Recommendations (*If necessary, return to Phase II to modify intervention(s), evaluation criteria and methodology*)
- Develop and Implement a Sustainability Plan for Ministry Focus Based on Evaluation Data And Other Constituent Input

REPLICATION AND EXPANSION (Phase IV)

- Replicate Interventions in Phase II in Other Locations (e.g., Other Episcopal Districts, Denominations, Faith Communities Worldwide)
- Expand SHINE Global Model into Another Ministry Focus (*Return to Phase I*)

The SHINE ministry project will emphasize steps that increase one's understanding of the extent of HIV/AIDS prevention and care activities within one jurisdiction of the AME Church. At project initiation, data will be available based on the ministry researcher's observations and field notes for the Second Episcopal District.[9] In addition, the interventions to be conducted include the introduction of the HIV/AIDS surveys at various levels of the Second Episcopal District of the AME Church (i.e., Episcopal District, District Conference and the local church). The ministry researcher will introduce the HIV/AIDS Survey to the Board of the Second District Religious, Educational and Charitable Development Projects, Inc., a non-profit corporation affiliated with the Second Episcopal District. Subsequently, the members of the Board will be asked to introduce the survey to participants at the Midyear Conference, and encourage them to participate in the study by completing the HIV/AIDS Survey.

Simultaneous in-depth interviews with various clergy leaders across the Second Episcopal District (i.e., Presiding Elders and Pastors) during the same timeframe will occur.[10] Interviews with the Bishop and Episcopal Supervisor who preside over the Second Episcopal District will be scheduled near the end of the project.

In addition, HIV/AIDS surveys similar to those noted above will be developed for the Eighteenth Episcopal District (including the countries of Botswana, Lesotho,

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[9] Some persons involved in anthropological research have also referred to the researcher's observation as participant observation. "It involves establishing rapport in a new community; learning to act so that people go about their business as usual when you show up; and removing yourself every day from cultural immersion so you can intellectualize what you've learned, put it into perspective, and write about it convincingly" H. Russell Bernard, *Research Methods in Cultural Anthropology* (Newbury Park, CA: Sage Publications, 1988), 148.

[10] The value of in-depth interviews in HIV/AIDS programs is discussed in: National Community AIDS Partnership, *Evaluating HIV/AIDS Prevention Programs in Community-Based Organizations* (Washington DC: National Community AIDS Partnership, 1993), 20-21. The significance of participant observation is also discussed on 21-23.

Mozambique and Swaziland) and for youth reached by Second Episcopal District congregations and outreach programs.[11] This will enhance international applicability of the SHINE Global Model, allow more age-appropriate assessments and provide comparison information.

Finally, as a part of the Phase I – Mobilization, initial steps will be taken to raise awareness of HIV/AIDS through various educational and promotional activities.

Research Design

A mixed method design will be used to combine both quantitative and qualitative methodologies.[12] A process will be used to alternate between the two types of data collection, including exploratory fieldwork, quantitative instrumentation, and qualitative work to increase understanding of issues in the context and the quantitative findings.[13] Nine steps are included in the design. Steps 1-5 will be quantitative and steps 6-9 qualitative.

1. Initiation of a pilot test of the HIV/AIDS Survey with twelve persons who belong to the Washington Annual Conference (October 2003).
2. Distribution of the HIV/AIDS Survey for completion by the Board of Directors of the Second District RED, Inc. (October 2003).

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[11] At the time of the writing of this document, instruments for the Eighteenth Episcopal District and with youth were designed but have not been pre-tested. Furthermore, a copy of an HIV/AIDS survey instrument used in the Nineteenth Episcopal District (South Africa) was obtained. Therefore, additional modifications of the survey international survey instrument will occur following the end of the project period for work in the Second Episcopal District.

[12] John W. Creswell, *Research Design: Qualitative and Quantitative Approaches* (Thousand Oaks, CA: Sage Publications, 1994), 173-190.

[13] Matthew B. Miles and A. Michael Huberman, *Qualitative Data Analysis: An Expanded Sourcebook* (Thousand Oaks, CA: Sage Publications, 1994), 41-42.

3. Distribution of the HIV/AIDS Survey for completion by clergy and laypersons from all five Annual Conferences, who attend the closing session of the Midyear Conference in Raleigh, North Carolina (November 2003).
4. Distribution of the HIV/AIDS Survey for completion by members of the Southern District of the North Carolina Annual Conference in the Wilmington, North Carolina area, who did not previously complete the survey (March 2004).
5. Distribution of the HIV/AIDS Survey for completion by members of Lee Memorial AME Church (March 2004).

The qualitative methodology will include in-depth interviews and observations.

6. Conduct in-depth interviews with Presiding Elders and Pastors throughout the Second Episcopal District (February 2004).
7. Conduct in-depth interviews with the Bishop and Episcopal Supervisor of the Women's Missionary Society of the Second Episcopal District (September 2004 and October 2004).
8. Review field notes, participant observations and related 1999 data from the Eighteenth Episcopal District international HIV/AIDS conference (ongoing).
9. Review of selected AME produced/utilized educational materials across the denomination, as well as previously survey results from the Nineteenth Episcopal District (South Africa).

The above components will represent the primary data sources to be used in the project. Steps four and five above will not be discussed at length, since the events of the Episcopal District level will be the emphasis for implementation for this project. Work at the District Conference and local church levels will serve to enhance

understanding of constituents' HIV/AIDS awareness and participation beyond Episcopal district-wide activities.

Sampling and Setting

Survey

A convenience sampling method will be used for administration of the survey at the Second Episcopal District Midyear Conference, the Southern District of the North Carolina Annual Conference, and Lee Memorial AME Church. Convenience samples will include persons who are present at the above conferences or locations during the time in which surveys are introduced and disseminated. These participants may also be called a "chunk sample" which is a non-probability sampling method.[14]

It should be noted that participation in the survey will be strongly encouraged by the presiding clergyperson (i.e., Bishop, Presiding Elder and Pastor), as well as lay leaders (HIV/AIDS Local Church Coordinator in the local church setting) prior to dissemination of surveys and subsequent collection of completed forms. Participation in the survey will be voluntary, with submission of a survey form as indication of consent. An estimate of surveys to be disseminated by context is found in Table 6.

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[14] "A chunk sample is simply a group of people who happen to be available at the time of the study. . ." Lu Ann Aday, *Designing and Conducting Health Surveys* (San Francisco: Jossey-Bass Publishers, 1989), 95.

Table 6. Summary of HIV/AIDS Surveys to be Disseminated in the African Methodist Episcopal Church		
LOCATION OF SURVEY ADMINISTRATION	**TOTAL NUMBER OF SURVEYS TO BE PREPARED FOR DISTRIBUTION***	**ESTIMATED NUMBER OF COMPLETED SURVEYS TO BE RECEIVED****
Second Episcopal District Midyear Conference	1000-1300	500
Southern District Conference of the North Carolina Annual Conference	150	75
Lee Memorial AME Church, post-worship service	50	35
TOTAL	**1200-1500**	**625**
* The total number of surveys that will be copied and prepared for distribution is based on estimated number of persons to be at the event. ** The estimated number of completed surveys is calculated based on the ministry researcher's experience with the context and modest estimates from the literature on response rates.		

The setting in which the survey will be administered will be at sites where previously scheduled events are being held. The Second Episcopal District Midyear Conference as well as the Board meeting of the Second District RED, Inc. will be held in a hotel in Raleigh, North Carolina.[15] The Southern District Conference will occur at a local AME Church within the Wilmington, North Carolina area. For Lee Memorial AME Church in Kensington, MD, the survey will be administered immediately following the 11:00 A.M. worship service.

[15] The meeting sites are typically determined and announced one year or more in advance. Written and verbal announcement of the Midyear Conference and Board Meeting are made through the Presiding Bishop's office and communicated at various levels of the church. The District Conference is scheduled by the Presiding Elder, and is communicated through the Pastors and lay members.

Denominational In-depth Interviews

Studies of multiple cases will be used for the qualitative research portion of this project. In-depth interviews will be conducted with a convenience sample of Pastors and Presiding Elders in each of the five Annual Conferences (i.e., Baltimore, Washington DC, Virginia, North Carolina and Western North Carolina) of the Second Episcopal District. Cases (persons to be interviewed) will be selected based on one or more of the following categories: convenience, critical, confirming or disconfirming, and politically important.[16] The following summarizes case classifications:

> Critical case – focuses, reduces, simplifies, facilitates group interviewing, it is the instance that 'proves' or exemplifies the main findings
>
> Confirming and disconfirming cases – elaborating initial analysis, seeking exceptions, looking for variation
>
> Politically important cases – attracts desired attention or avoids attracting undesired attention, 'salient' informants who may need to be included (or excluded) because they connect with politically sensitive issues anticipated in the analysis
>
> Convenience cases – Saves time, money and effort, but at the expense of information and credibility.[17]

The overall aim is to select cases for the in-depth interviews that will enhance generalizability and internal validity.

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[16] Miles and Huberman, *Qualitative Data Analysis*, 28. Sixteen sampling strategies in qualitative inquiry are provided in this reference.

[17] Ibid.

At project initiation, there are ten Presiding Elders serving on the Second Episcopal District.[18] The goal is to interview five Presiding Elders, at least one Presiding Elder in each Annual Conference. To date, there are 367 churches being pastored within the Second Episcopal District. Similarly, the goal is to interview five Pastors, at least one from each Annual Conference.[19]

Interviews with the Episcopal District leadership will also be conducted. The Presiding Bishop and the Episcopal Supervisor will be interviewed to obtain a greater understanding of their overall vision and perspectives on the need for HIV/AIDS prevention and care interventions in the Second Episcopal District.

Instrumentation

Surveys

The HIV/AIDS surveys will be administered within the Second Episcopal District. Prior to administration, a pilot test will be conducted with persons located in the region of the Washington Annual Conference (i.e., Washington DC, Maryland and Northern Virginia). After the pilot test, a survey will be administered at the Second Episcopal District Midyear Conference, at the Southern District of the North Carolina

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[18] At project conclusion, there were 11 Presiding Elders. A third Presiding Elder Position was added to the Western North Carolina Annual Conference in June 2004.

[19] Wherever possible, male and female Pastors will be interviewed to eliminate gender bias. The ideal scenario is for 10 pastoral interviews (one male and one female) to be conducted from each Annual Conference. Only one female Presiding Elder is currently serving the Second Episcopal District.

Annual Conference, and with a local church, with Lee Memorial AME Church within the Washington Annual Conference.[20]

Survey items were obtained from the ministry researcher's personal experience in conducting HIV/AIDS projects, and from the literature (e.g., research studies, brochures, pamphlets and conferences). In addition, survey items will be developed by the ministry researcher in consultation with a Professional Associate with expertise in the area of HIV/AIDS.[21]

Overall, all the surveys will be designed to be brief (five to ten minutes to complete), with minimal instructions. The survey instrument will be one page in length, with only the front side being utilized.

Pilot Study of the HIV/AIDS Survey

The pilot study of the HIV/AIDS Survey will be completed using a convenience sampling method among persons in the Washington Annual Conference of the AME Church. The study will be conducted to assess clarity of items, establish an average completion time and assess the reliability of survey items. Readability analysis of the entire instrument will be performed by the researcher using the Flesch Reading Ease score and the Flesch-Kincaid Grade Level score.[22]

The pilot will be administered by a staff person from the Pilgrim Community Outreach Corporation under the direction of the ministry researcher and a Professional

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[20] See the Field Experience section for further information on the survey results from the three populations. Copies of instruments are in Appendix D.

[21] The Professional Associate who assisted with this was Dr. Veronica Clarke-Tasker, faculty member at Howard University.

[22] Microsoft Office software includes the Flesch Reading Ease and the Flesch-Kincaid Grade Level score as a part of its program.

Associate. Persons will be recruited from ministries affiliated with Pilgrim AME Church in Washington DC. The sample characteristics will be similar to those required of a larger sample.

Following the pilot test, the original HIV/AIDS Survey will be analyzed and revised accordingly. The revised HIV/AIDS Survey will be disseminated to the Second Episcopal District Midyear Conference, the Southern District Conference and Lee Memorial AME Church.

Second Episcopal District Midyear Conference

The ten-item survey instrument from the pilot test will be revised, after pre-testing with members from the leadership of the Second District Religious, Educational and Charitable Development Projects, Inc. Following incorporation of any suggested revisions, the survey will be disseminated to members of the Board of Directors of Second District RED, Inc.

After Board approval, the survey will be disseminated to participants at the Midyear Conference in Raleigh, NC. Three appeals will foster completion of the surveys: 1) Announcement about the survey from the conference floor just prior to dissemination; 2) Reiteration of the purpose and request of participants to complete the surveys during the public reading of the Second District RED, Inc. report; and 3) Final appeal to turn in completed surveys at the close of the conference. All participants will be asked to fold the survey form, and return their confidential surveys to a designated representative as soon as completed. Designated representatives will include the ministry researcher, staff of the Pilgrim Community Outreach Corporation (PCOC) which is the co-sponsoring

organization, and a volunteer(s) who will be instructed by the ministry researcher on the procedures for collecting the completed forms. Those collecting the instruments will have a box, envelope or other sealed container in which survey respondents can deposit their folded forms. All staff and volunteers will be instructed to ask participants to put concealed forms directly into the container.

All completed forms will be given to the ministry researcher at the close of the event. PCOC staff will be asked to total the number of surveys received by Annual Conference at a later time. Forms will then be returned to the ministry researcher to proceed with data collection/analysis activities.[23]

Southern District of the North Carolina Annual Conference

The survey instrument to be used at the Midyear Conference (see above section) will also be administered at the Southern District Conference that is a part of the North Carolina Annual Conference. The process for dissemination of the survey will be similar to that at the Second Episcopal District Midyear Conference with a few notable differences.

1. The Presiding Elder (the Chairperson of the Meeting) will introduce the survey and make an appeal to the constituents to complete the survey.
2. The ministry researcher is scheduled to do a HIV/AIDS awareness workshop at the District Conference in Wilmington, North Carolina area.
3. Persons who attended the Midyear Conference in Raleigh, North Carolina, and completed a survey will not be asked to do so again at the District Conference.
4. The ministry researcher will be the only designated person to collect the surveys.

[23] See Chapter Five, "Field Experience."

All other procedures for survey administration will be the same as for the Midyear Conference.

Lee Memorial AME Church

The survey instrument to be used at the Midyear and Southern District Conferences (see above sections) will also be administered at the local church, Lee Memorial AME. If the survey were to be administered at numerous other local churches across the Second Episcopal District, changes in administration to resemble what was done at Lee Memorial will be necessary. In such instances, it would not be feasible due to time and logistics for a Pastor or a PCOC staff person to introduce the survey to the congregation. More likely, a lay person would be asked to disseminate the survey and return forms to the ministry researcher. Among the options available in a given local context: the lay person may be an individual designated by the Pastor for this special assignment, or someone who already is associated with health and/or HIV/AIDS-specific awareness issues. Several adaptations to survey administration will occur for dissemination at Lee Memorial AME Church.

1. The HIV/AIDS Local Church Coordinator will receive verbal instructions (via in-person meeting or telephone) by the ministry researcher on how to administer the forms. Procedures for maintaining confidentiality will occur.
2. The Local Church Coordinator will be the person to introduce the survey to congregation at a designated point approved by the Pastor of the church.

3. An envelope will be provided for the Local Church Coordinator to collect surveys, seal the package and return to the ministry researcher the same day or as soon as possible.
4. The ministry researcher will obtain feedback from the Local Church Coordinator on any special issues that arise, and overall observations of the process.

The ministry researcher will be responsible for tallying the surveys and preparing forms for data collection.

Denominational In-depth Interviews

Understanding members of faith communities' perspectives on HIV/AIDS is essential to the development of effective programmatic activities. Therefore, a series of in-depth interviews will be conducted with denominational leadership within the Second Episcopal District within the AME Church including the following: 1) Pastors, 2) Presiding Elders, 3) Episcopal Supervisor, and 4) Bishop. The purpose of the interviews is to obtain greater insight into the opportunities and challenges to increasing HIV/AIDS prevention and care activities. The unique perspectives at various levels of the AME Church infrastructure are expected to provide guidance for future project implementation.

Based on her experience with the context, the ministry researcher developed in-depth interview questionnaire items. The interviews will be semi-structured, allowing the ministry researcher flexibility to probe into areas of interest discovered during an interview. The instrument includes seven items as well as additional background questions. A "Summary In-depth Interview Guide" will be developed for each type of interview to be conducted. Upon request, to aid in telephone interviews, a copy of the

summary instrument will be faxed to prospective interviewees. The ministry researcher will use an interview guide for each type of interview. A confidentiality statement will be made at the time of the interview, and verbal consent to be included in the study will be obtained. All persons participating in the in-depth interview will be asked if they agree to have the session tape-recorded. Regardless of response, the ministry researcher will take hand-written notes during the course of the interviews.[24]

Participant Observation

The ministry researcher's ongoing assessment of the project is vital to the action research process. Field notes from the ministry researcher's journals from 1999 through 2004 will be used as a supplemental source of project information. In addition, other resources such as videotapes, meeting notes and proceedings etc. will be consulted on an ongoing basis.

Measurements

Measurements for the survey and in-depth interviews are described in this section.

Surveys

Surveys will be used to measure the following four areas: 1) extent of participation in health awareness activities, 2) extent of participation in HIV/AIDS awareness activities, 3) likelihood of support of HIV/AIDS projects, and 4) knowledge of

[24] See Appendix D for copies of instruments and a sample of the interview guide.

HIV/AIDS transmission. Describers of the sample will also be collected.[25] Measurements used in this project will assign numbers to each survey item based on the kind or amount of an attribute.[26]

Extent of Participation in Health Awareness Activities

The extent of an individual's participation in health awareness activities at three levels of the Second Episcopal District will be assessed. One survey item with a three-part response will be used to achieve this (Question Three). This question asks for yes or no responses to whether the respondent has ever attended a health presentation or workshop at any of the following events: a) Second Episcopal District Event, b) Local Church or c) District Conference. A positive (yes) response will indicate the respondent's participation in a health presentation or workshop.

Extent of Participation in HIV/AIDS Awareness Activities

The extent of an individual's participation in HIV/AIDS awareness activities at three levels of the Second Episcopal District will be assessed. Four survey items will be used to achieve this (Questions Four, Five, Six, and Nine). A three-part response is required in Question Four. This question asks for "yes" or "no" responses to whether the respondent has ever attended an HIV/AIDS presentation or workshop at any of the following events: a) Second Episcopal District Event, b) Local Church or c) District

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[25] See Appendix D for copy of the survey instrument. Participant's Annual Conference affiliation, lay or clergy status, age, gender and ethnic group are included as describers of the sample.

[26] Carolyn Feher Waltz, Ora L. Strickland and Elizabeth R. Lenz, *Measurement in Nursing Research* (Philadelphia, PA: F. A. Davis Company, 1991), 2, 61-64.

Conference. A positive (yes) response will indicate the respondent's participation in an HIV/AIDS presentation or workshop.

Question Five, in a two-part format, asks the individual to expound upon Question Four. Again, the respondents are asked whether or not they have ever attended an HIV/AIDS presentation or workshop, by indicating "yes" or "no." If the response is yes, an open-ended follow-up response is requested on when and where this occurred.

Question Six will ask respondents if they have ever reviewed any HIV/AIDS literature. Respondents were asked to check all the categories that apply including: pamphlets, fact sheets, brochures and videos.

Question Nine will measure recent involvement in HIV/AIDS. It requests information on whether or not in the past year the individual or any member of the clergy has discussed HIV/AIDS with members of the congregation. Yes, No and Don't Know are the possible responses.

Likelihood of Support of HIV/AIDS Projects

Two survey items will measure the likelihood of an individual to support HIV/AIDS projects in the United States and Southern Africa (Questions Seven and Eight). This category of questions will be helpful to future project planning. Question Seven asks about likelihood to support an HIV/AIDS church-based awareness project among African Americans; Question Eight is on the likelihood of supporting a project in Southern Africa. Five possible responses were given for each question including the following: Very Likely, Somewhat Likely, Unlikely, Not At All, and Unsure.

Knowledge of HIV/AIDS Transmission

Question Ten assesses an individual's awareness of how HIV/AIDS is transmitted. Scientifically known modes of transmission (sexual contact, intravenous (IV) needle sharing, and blood transfusions) are included. Only mother-to-child transmission was excluded from choices. In addition, myths are included which are not scientifically supported means of transmission are reported (i.e., kissing and toilet). Respondents were asked to check all the categories that apply, including items in this order: Kissing, Sexual Contact, IV Needle Sharing, Blood Transfusions, and Toilet.

Describers of Sample

Two questions will address the characteristics of the sample (Questions One and Two). This data will allow the ministry researcher to analyze data by context-specific categories and demographics. Question One will be in two parts, with the respondents being asked to check all that apply for the entire question. First, the item assesses the respondent's Annual Conference affiliation within the Second Episcopal District: Baltimore, Washington, Virginia, North Carolina and Western North Carolina. Second, the respondents will be asked to indicate whether they were clergy or a lay person.

Demographic information regarding age, gender and ethnic/racial group will be measured in Question Two. Age and ethnic/racial group will be open-ended questions whereas for gender, respondents could check whether they were male or female.

Denominational In-depth Interviews

In-depth interviews will be used to explore the overall perceived extent of readiness of constituents in the Second Episcopal District to address HIV/AIDS (Research Question Three). This component of the qualitative research for the project will include questions that relate to both the quantitative survey described in the above section, and also to unique questions and background information for the interview.

Extent of Awareness of HIV/AIDS and Other Health Issues: Relationship and Insight on Quantitative Component (Survey Items Four, Five and Nine)

Three questions relate to survey items (i.e., Interview Questions One, Three and Four). Interview Question One asks whether or not the person interviewed was aware of the HIV/AIDS survey disseminated at the 2003 Midyear Conference in Raleigh, NC. A follow-up question is whether or not the person completed the survey. The purpose of this question is to determine the familiarity with the survey and the effort to better understand HIV/AIDS awareness in the Second Episcopal District.

Interview Question Three is an open-ended question regarding the interviewees' awareness of churches or agencies in their areas (or specific jurisdiction of responsibility) that are engaged in efforts which address HIV/AIDS. This interview question relates to HIV/AIDS Survey Questions Four, Five and Nine, regarding attendance at an HIV/AIDS presentation or workshop, when and where attended an HIV/AIDS presentation/workshop and if HIV/AIDS was discussed in the church congregation in the past year respectively.

The fourth interview question asks what health presentations were held under the leadership of the respondent, and when they occurred. Question Four inquires whether

HIV/AIDS were addressed in previous presentations. The question relates to HIV/AIDS Survey Question Three on attendance at a health presentation or workshop at a Second Episcopal District, Local Church or District Conference event.

Readiness to Address HIV/AIDS: Relationship and Insight on Quantitative Component (Survey Items Seven and Eight)

The overall aim of Interview Questions Two, Five, Six and Seven is to determine the perceived readiness of the AME Church at different levels (i.e., Episcopal District, District Conference and Local Church) to address HIV/AIDS. This is accomplished by first asking persons to rank on a scale of one to five (where five is high and one is low) their perception of the overall readiness to address HIV/AIDS at the level they primarily serve (Interview Question Two). In addition, identification of level-specific opportunities (Interview Question Five) and challenges (Interview Question Six) for implementing an HIV/AIDS project will be explored.

Interview Question Seven will show how open the individuals interviewed are in their position to help raise awareness of HIV/AIDS. If the people are open, then follow-up questions will include asking what could assist the persons in raising awareness, as well as what concerns or conditions might hinder his/her involvement.

The four interview questions in this readiness category link to HIV/AIDS Survey Questions Seven and Eight. These survey questions pertain to the likelihood of supporting a church-based HIV/AIDS project among African Americans as well as a project in Southern Africa.

Describers of Sample

Specific information will be included in the in-depth interview to assist in identifying demographic and other data helpful in understanding the background of the interviewee. This data includes: length of time in pastorate or in current capacity; length of time in ordained ministry or as Episcopal Supervisor; Annual Conferences served; classification of urban, rural and suburban; size of church or district; highest educational level achieved; race; and gender. Background information will be tailored to correspond to the primary level of service that the person serves (e.g., Episcopal District, District Conference and Local Church).

CHAPTER FIVE

FIELD EXPERIENCE: SECOND EPISCOPAL DISTRICT, AFRICAN METHODIST EPISCOPAL CHURCH

This chapter presents the major results of the *SHINE Global Model for Second Episcopal District Mobilization for HIV/AIDS Prevention and Care Using Government and Faith-based Initiatives*. The chapter includes: collection of data; analysis of data; and outcomes. Both quantitative and qualitative data for the 2003-2004 project period are included in the outcomes section. Quantitative outcomes data is limited to the frequency data of the 2003 Midyear Conference HIV/AIDS Survey, and significant difference findings related to the research questions. Qualitative outcomes data is limited to the questions involving the: a) perceived readiness of the different levels of the AME Church to engage in HIV/AIDS prevention and care activities and b) the opportunities and challenges to implementing an HIV/AIDS project. In addition, findings from mobilization efforts are provided.

Collection of Data

Data was collected in five settings: 1) pilot study in Washington DC; 2) Midyear Conference of the Second Episcopal District in Raleigh, North Carolina; 3) Southern District Conference (Navassa, North Carolina); and 4) Lee Memorial AME Church in Kensington, Maryland; 5) telephonic interviews from Kensington, Maryland; and 6) Second Episcopal District mobilization events.

Key Aspects of Data Collection

Several aspects helped facilitate data collection: ongoing communication with leadership; announcements and other reinforcements to encourage survey participation; assurance of confidentiality; and preliminary sharing of results with leadership. In each phase of the data collection, these elements were critical to obtaining responses from Second Episcopal District constituents, and support of the key leaders. This ministry research project consisted of three sample populations: 1) Second Episcopal District Midyear Conference; 2) Southern District of the North Carolina Annual Conference; and 3) Lee Memorial AME Church. Only data from the Second Episcopal District Midyear Conference is analyzed in this document.

The Midyear Conference surveys comprise the quantitative data for this project, and were conducted using a convenient sampling method. There were four hundred and seventy-one (471) persons who completed the Midyear survey.[1] In addition, qualitative data (through in-depth interviews) was also collected. There were nine in-depth interviews conducted among selected leaders in the Second Episcopal District including: the Bishop, the Episcopal Supervisor, five Presiding Elders and two Pastors. The sections that follow discuss key steps employed for data collection.

Pilot Study – October 2003

Persons affiliated with the African Methodist Church were recruited in Northeast Washington DC to participate in the pilot study. The pilot of a survey instrument

[1] A total of 570 surveys were collected during the project period (i.e., 471 at Midyear, 69 at the Southern District and 30 at Lee Memorial).

(a paper and pencil test) was completed by twelve persons using a convenient sampling method. The pilot sample consisted of five African American men and seven African American women. The age range was twenty-six to seventy-three years. A staff person of the Pilgrim Community Outreach Corporation administered the surveys after consulting with the ministry researcher and a Professional Associate. Time required to complete the survey (approximately five to seven minutes) and ease of understanding intent of questions were primary factors observed. All participant surveys were kept confidential and anonymity was maintained.[2]

Readability

The readability of the survey instrument was also calculated. Readability scores assist in determining the ease of reading a document and rates the text on a United States grade-school level. Two measures were used for the survey: 1) Flesch Reading Ease score which uses a 100-point scale, with the aim of 60-70 for most standard documents (with the higher the score indicating that it is the easier to read) and 2) Flesch-Kincaid Grade Level score in which the score indicates the typical grade level, with the aim for a score of approximately 7.0 to 8.0.

The pilot study instrument (as well as the Midyear Conference, District Conference and local church instruments) yielded the following readability scores: 57.9 for the Flesch Reading Ease score and 7.2 for the Flesch-Kincaid Grade Level score. It may be that Flesch Reading Ease score may be lower than the aim, because the standard was not set for research material.

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[2] See Appendix E for additional pilot study data.

Midyear Conference – October/November 2003

The survey was first introduced to the Board of Directors of the Second District Religious, Educational and Charitable Development Projects, Inc. This board meeting occurred on Thursday, October 30, 2003 in Raleigh, North Carolina. Final survey formatting occurred following this meeting, and included a note to instruct participants in the Midyear Conference to fold surveys before submitting them.

The surveys were distributed at the closing session of the Midyear Conference, Saturday, November 1, 2003 in Raleigh, North Carolina. The purpose of the confidential survey was to determine the educational needs of laity and clergy within faith-based institutions regarding HIV/AIDS, specifically members of the Second Episcopal District of the African Methodist Episcopal Church. See Table 7 for the distribution of surveys received by Annual Conference.

Convenience samples included persons who were present at the above meeting and conference or locations during the time in which surveys were introduced and disseminated. The Pilgrim Community Outreach Corporation volunteers assisted in the distribution and collection of folded surveys.

Table 7
Number of Surveys Received during the 2003 Midyear Conference By Annual Conference

Baltimore	Washington	Virginia	North Carolina	Western North Carolina	Non-Conference Participants	Total
63	134	80	104	86	4	471

Readability

There were no major changes in the survey after the pilot instrument. Therefore, the Midyear Conference HIV/AIDS survey yielded the same readability scores: 57.9 for the Flesch Reading Ease score and 7.2 for the Flesch-Kincaid Grade Level score.

Reliability

Internal consistency reliability was determined by calculating Cronbach's Alpha. Internal consistency reliability is defined as "the consistency of performance of one group of individuals across the items on a single measure."[3] "Alpha measures the extent to which performance on any one item on an instrument is a good indicator of performance on any other item on the same instrument."[4] Alpha coefficients range from zero to one, and the higher the coefficient the better. If there is a high alpha value, it means that there is a high item intercorrelation (i.e., evidence that the test as a whole is measuring just one attribute such as attendance at HIV/AIDS presentations/workshops).

Reliability analysis using Cronbach's Alpha was conducted for Survey Questions Four and Five regarding the extent these items measured the participants' attendance at HIV/AIDS presentations or workshops at the Second Episcopal District, District Conference and local church levels, as well as in any setting (including but not limited to

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[3] C. Waltz, Ora L. Strickland and Elizabeth R. Lenz, *Measurement in Nursing Research* (Philadelphia, PA: F. A. Davis Company, 1991), 166.

[4] Ibid.

an AME setting). The alpha coefficient was high at 0.757. This indicates that over 75% of the time, what was intended that the question answer occurred, yielding a high internal consistency.[5]

Southern District Conference – March 2004

At the District Conference, presentations occurred on issues such as sexuality, purity, and HIV/AIDS. The Presiding Elder of the District Conference requested the ministry researcher to come to the Wilmington, North Carolina area (Navassa) to conduct an HIV/AIDS workshop. The Presiding Elder inquired of participants whether they had other health presentations prior to her tenure. She encouraged persons to complete the HIV/AIDS Survey, which was circulated simultaneously with her remarks. Only those persons who did not participate in the Midyear Conference survey were eligible. Participation in the study was voluntary. Therefore, willingness to complete the survey implied consent. Volunteers (pre-selected and local church ushers) assisted in the dissemination of surveys. The ministry researcher received folded surveys directly from respondents. Sixty-nine surveys were received.

Local Church – March 2004

The ministry researcher briefed the Local Church Coordinator on the HIV/AIDS survey and procedures for data collection and for maintaining confidentiality. A local church health coordinator disseminated the surveys during a Sunday service immediately following the announcement. The ministry researcher was not present for the

[5] See Appendix E for additional data.

dissemination. Thirty folded surveys were collected, stored in an envelope and later submitted to the ministry researcher.

In-depth Interviews

In order to assess the readiness of constituents of the Second Episcopal District to engage in further HIV/AIDS awareness activities, in-depth interviews with key leaders was the method chosen to obtain these perceptions. Background information on the interviewee and seven other questions were asked. In-depth interview questions were designed to provide insight to selected Midyear Conference survey questions.[6]

Interviews were arranged with Pastors and Presiding Elders of the five Annual Conferences. In addition, interviews with the Presiding Bishop and Episcopal Supervisor were conducted.[7] All persons requested to participate expressed a willingness to discuss HIV/AIDS issues and awareness efforts in the AME Church. A total of nine interviews were conducted: eight telephone interviews and one face-to-face interview. Three additional interviews were planned, but it was not possible to schedule them at a suitable time during the data collection period. Flexibility was essential due to the dynamic schedules of ministers. Funerals, travel, local church emergencies were among some the reasons that some interviews had to be rescheduled.

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[6] Appendix D contains sample in-depth interview forms. Analysis methods and outcomes for the qualitative research (i.e., interviews) are found later in this chapter and selected transcripts in Appendix F. See Chapter 4, "Methodology," pages 141-143 for information on the relationship between the interview and survey questions.

[7] During the project period Episcopal leadership changed from Bishop Vinton R. Anderson to Bishop Adam J. Richardson, Jr. The Second Episcopal District level in-depth interviews were conducted with Bishop Richardson, and the Episcopal Supervisor, Mrs. Connie S. Richardson.

Analysis of Data

Quantitative Data Analysis

The quantitative data used in this project were analyzed using the Statistical Package for the Social Sciences (SPSS)[8]. Characteristics of the sample for the Second Episcopal District using the Midyear Conference survey results will be described using frequency distributions, descriptive statistics, and correlation coefficients. The Southern District Conference and Lee Memorial AME Church data will be used for analysis in future studies.[9]

Overview of Quantitative Analysis by Research Question

The first two research questions primarily dealt with quantitative data, with limited insights from qualitative data (discussed later). In Research Question One, frequencies and chi-square analysis were used to determine the relationship between participation in health and/or HIV/AIDS presentations or workshops, and the independent variable Annual Conference affiliation. Similarly, in Research Question Two, frequencies and preliminary chi-square analysis was used to determine the relationship between the independent variables Annual Conference affiliation and respondents'

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[8] Darren George, and Paul Mallery, *SPSS for Windows Step by Step: A Simple Guide and Reference* (Boston, MA: Allyn and Bacon, 2003). Specific software versions used include SPSS 10.0 and 15.0.

[9] At the initiation of this ministry research project, only the Midyear Conference survey administration was envisioned. However, after the overall project period was extended, additional opportunities became available to distribute surveys at other levels of the AME Church (i.e., District Conference and local church levels). As the overall data collection period ended, it was determined that the inclusion of all three levels of the church may be beyond the scope of this project, although this data will still be helpful later for the purposes of comparison and continued mobilization efforts.

willingness to support a church-based HIV/AIDS awareness project focused on African Americans, as well as an HIV/AIDS project focused on Southern Africa. Supplemental quantitative data on HIV/AIDS literature reviewed and the perceived modes of HIV/AIDS transmission were also given. Other statistical tests were also conducted to assist with the analysis using SPSS.[10]

Frequencies

Frequencies in 2003 Midyear Conference Data were taken for each survey item. In the "Outcomes" portion of this chapter, frequency data appears in four sections: 1) Overview of Survey Participants; 2) Quantitative Data Analysis of Research Question One; 3) Quantitative Data Analysis for Research Question Two; and 4) Supplemental Quantitative Data Results.

Significance Findings

The variable of particular concern for the analysis of relationships in the data was Annual Conference affiliation. Relationships between this variable and key survey items were important for better understanding HIV/AIDS awareness trends in the Second Episcopal District of the AME Church. The Annual Conference variable was also helpful to understand suitable approaches for future denominational mobilization efforts based on geographic location.

Significant differences were found in several categories of the data obtained. This was determined using one-sample chi-square (χ^2) tests, which indicated significant differences when there was a deviation from the assumption that the given

[10] Ibid.

indicators occur in equal frequencies. Tests on two variables (e.g., HIV/AIDS presentation/workshop attendance) were considered significantly different if $p \leq .05$. This means that there is a strong likelihood that there was a relationship between variables, and that this relationship did not likely occur by chance.

The SPSS 10.0 and 15.0 software programs were used to conduct chi-square and other analysis tests. The results from the 471 respondents to the 2003 Midyear Conference HIV/AIDS Survey are summarized on the pages that follow.

Qualitative Data Analysis

The qualitative data in this project included in-depth interviews and participant observations. Major trends among clergy and lay leadership in response to questions such as: familiarity with survey instrument; perceived readiness of churches (and ministries within the church such as missionary societies and lay organizations) to address HIV/AIDS; awareness of other churches engaged in HIV/AIDS ministry; conduct of denominational health and/or HIV/AIDS presentations; major opportunities and challenges to implementing an HIV/AIDS project in the Episcopal District; and openness of leadership to use their positions to help raise awareness on HIV/AIDS. As stated earlier in the introduction of this chapter, emphasis in this document has been placed on the results of perceived readiness of churches to address HIV/AIDS, as well as the major opportunities and challenges to implementing an HIV/AIDS project in the Episcopal District.

Mobilization Efforts

The ministry researcher was able to work directly on mobilization efforts as part of her role serving as Director of Health and Wholeness for the Pilgrim Community Outreach Corporation (PCOC) in collaboration with the Second District RED, Inc. The Pilgrim Community Outreach HIV/AIDS Series for Member Denomination Project" was supported by the United States Department of Health and Human Services, Office of Minority Health. The ministry researcher served as the Program Director for this project and an earlier related grant, and led efforts to write the original proposals and provided primary day-to-day oversight of administrative and programmatic activities.

The analysis of results and dialogue on the project with the public sector officials occurred on an ongoing basis. This was consistent with the SHINE Global Model's aim to include networking with government and faith-based initiatives. Working with the staff of PCOC, various aspects of the ministry model were implemented to demonstrate mobilization efforts in the Second Episcopal District. The ministry researcher summarized efforts according to the SHINE Global Model focal areas for analysis in this project.

Outcomes

The outcomes section is divided into six parts: 1) Overview of HIV/AIDS Survey Participants; 2) Quantitative Results for Research Question One; 3) Quantitative Results for Research Question Two; 4) Supplemental Quantitative Results; 5) Qualitative Results for Research Question Three; and 6) Mobilization Efforts.

Overview of HIV/AIDS Survey Participants at the
2003 Midyear Conference

The majority of respondents to the HIV/AIDS Survey included those who attended the Second District RED, Inc. Board meetings and/or the Midyear Conference.

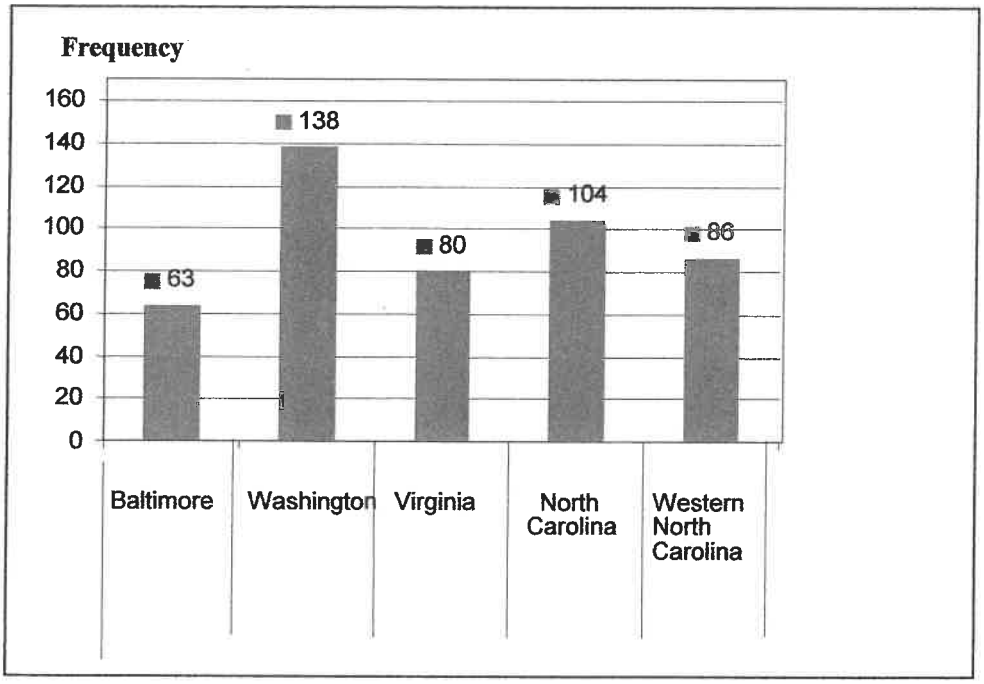
Annual Conference Affiliation

Four hundred and seventy-one (471) persons from all five annual conferences participated in the survey. The results are displayed in Table 8 and Figure 3. The largest percentage of participants was in the Washington Annual Conference (29.3%).

Table 8. Annual Conference Affiliation Frequencies

Conference		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Baltimore	63	13.4	13.4	13.4
	Washington	138	29.3	29.3	42.7
	Virginia	80	17.0	17.0	59.7
	North Carolina	104	22.1	22.1	81.7
	Western North Carolina	86	18.3	18.3	100.0
	Total	471	100.0	100.0	

Figure 3. Annual Conference Affiliation Bar Graph



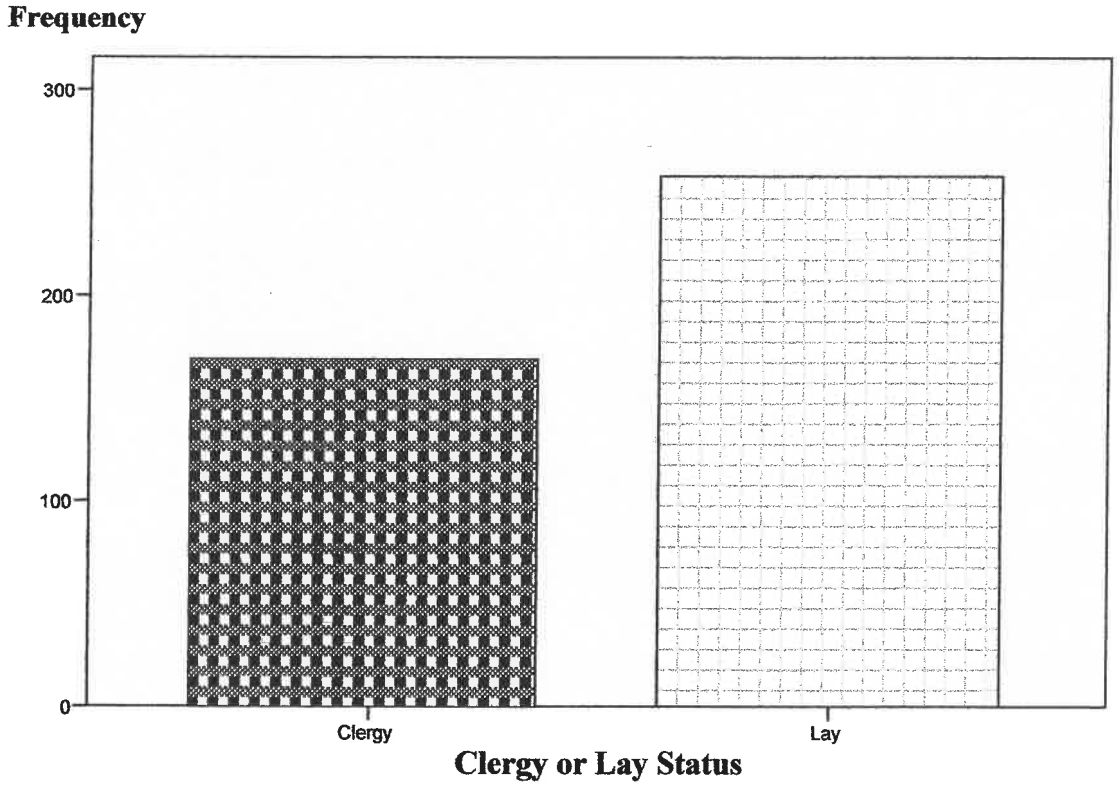
Clergy/Lay Status

There were 169 Clergy and 258 Laypersons participants in the survey. Approximately 44 persons did not respond to the question on clergy/lay status. The breakdown of respondents by Annual Conference is provided in Table 9 and Figure 4.

Table 9. Clergy or Lay Status Frequencies

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Clergy	169	35.9	39.6	39.6
	Lay	258	54.8	60.4	100.0
	Total	427	90.7	100.0	
Missing	45.00	1	.2		
	Missing	43	9.1		
	Total	44	9.3		
Total		471	100.0		

Figure 4. Clergy or Lay Status Bar Graph



Age

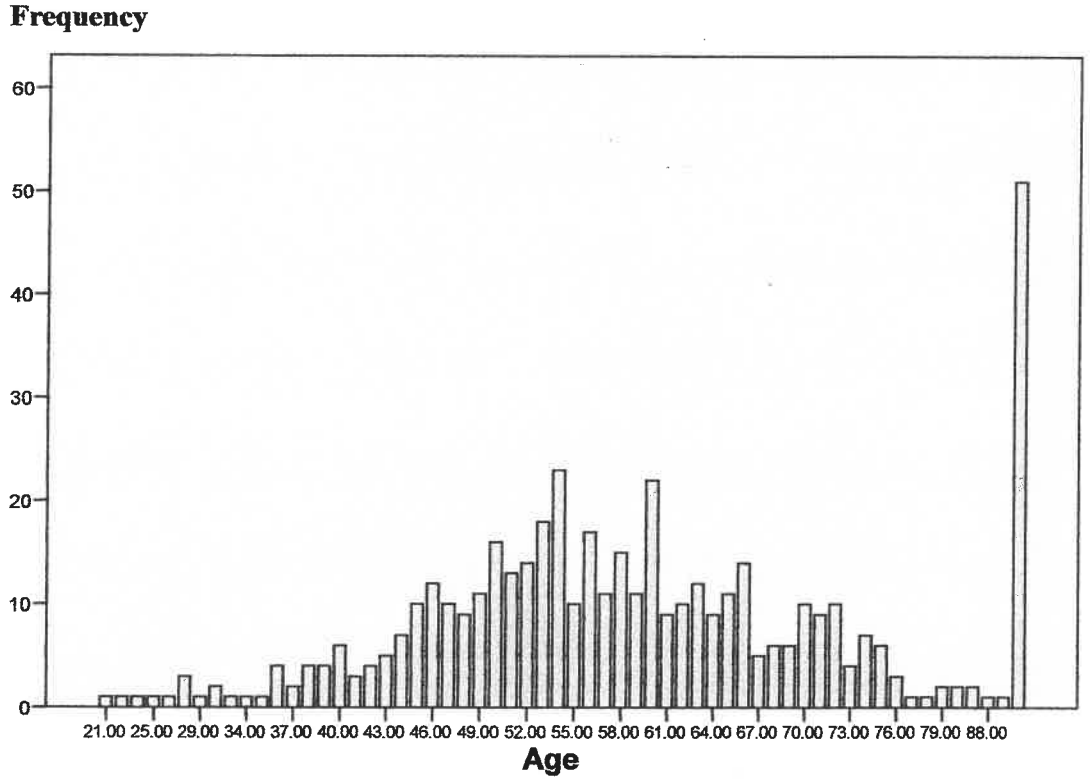
The age range of survey participants was 21-90, with the mean age of 61 and median age as 58, Standard Deviation was 17. Age Frequencies are found in Table 10 (grouped) and Figure 5 (pictorial representation) that follow.[11]

[11] The spike at the end of the Figure 5 (at about 92) is a standard reference bar.

Table 10. Age Frequencies

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Group 1 – Ages 21-39	28	5.9	6.0	6.0
	Group 2 – Ages 40-60	247	52.4	52.9	58.9
	Group 3 – Ages 61-90	192	40.8	41.1	100.0
	Total	467	99.2	100.0	
Missing	System	4	.8		
Total		471	100.0		

Figure 5. Age Frequencies Bar Graph

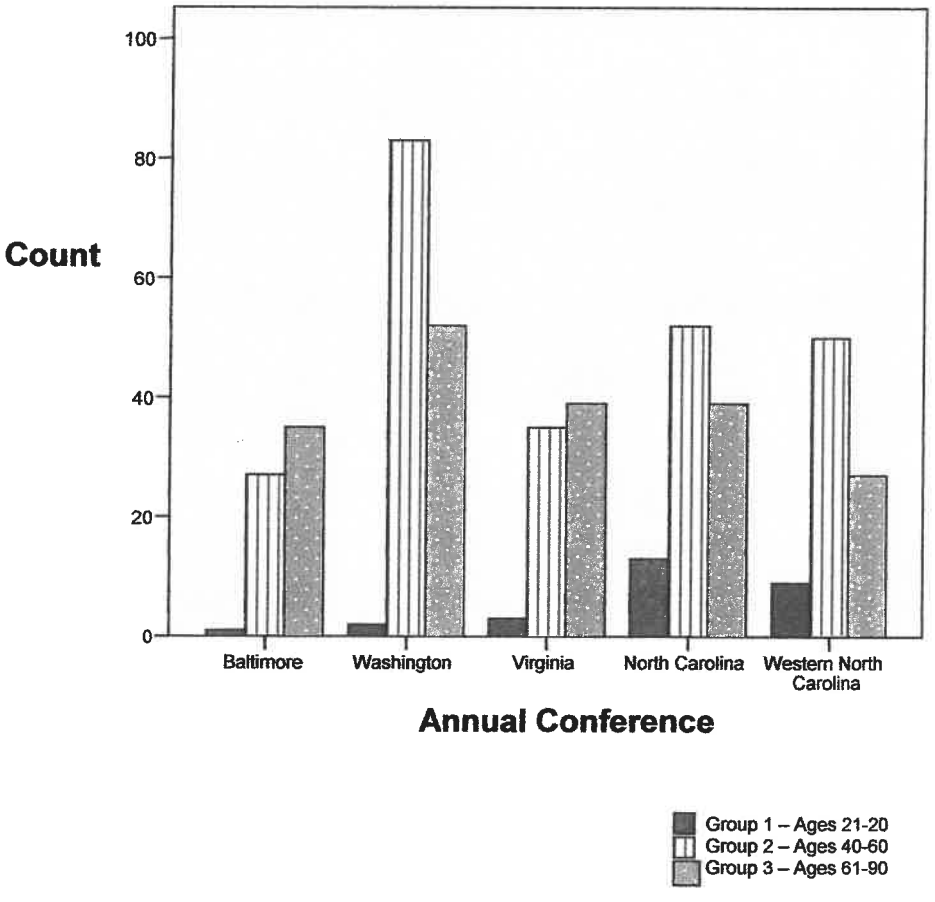


Significance Findings

There *were significant differences* found in the age of participants in the survey according to Annual Conference affiliation. A one-sample chi-square test was conducted

to assess whether there were significant differences in participation by age based Annual Conference affiliation. The results of the test *were* significant, χ^2 (N=467) = 29.199, p = .000.[12] The proportion of participants who participated in the survey *did* differ significantly by age across the Annual Conferences. See Figure 6.

Figure 6.
Age and Annual Conference Affiliation - Bar Graph



[12] As noted above in "Analysis of Results," results of $p \leq .05$ were considered significantly different.

Gender

As seen in Table 11 that follows, the majority of valid respondents were female (71%), and 29% were males.

Table 11. Gender Frequencies

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	126	26.8	29.0	29.0
	Female	309	65.6	71.0	100.0
	Total	435	92.4	100.0	
Missing	Missing	36	7.6		
Total		471	100.0		

Significance Findings

There were no significant differences in gender participation in the survey according to Annual Conference affiliation. A one-sample chi-square test was conducted to assess whether there were significant differences in participation by gender based Annual Conference affiliation. The results of the test were *not* significant, χ^2 (N=435) = 1.753, p = .781. The proportion of participants who participated in the survey did not differ significantly by gender across the Annual Conferences.

Race

All valid respondents (100%) who completed this open-ended question identified themselves as Black or African American. As Table 12 indicates, the 317 participants who responded to this question represent 67.3% of the total survey respondents.

Table 12. Race/Ethnic Group Frequencies

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Black	182	38.6	57.4	57.4
	African American	135	28.7	42.6	100.0
	Total	317	67.3	100.0	
Missing	Missing	153	32.5		
	System	1	.2		
	Total	154	32.7		
Total		471	100.0		

Quantitative Results for Research Question One

The first research question asked, as related to participants' Annual Conference affiliation, to what extent members: attended a health and/or HIV/AIDS presentation or workshop at selected AME Meetings; ever attended a HIV/AIDS presentation or workshop (in any AME or other setting and when it occurred); and shared or heard a clergyperson discuss HIV/AIDS with the church congregation.

Past Attendance at Selected AME Church Meetings for a Health or HIV/AIDS Presentation/Workshop

The extent of an individual's participation in health or HIV/AIDS awareness activities at three levels of the Second Episcopal District was explored. The three levels were selected because of known activities conducted by Second District RED, Inc. and/or local constituents. Three levels of AME meetings are represented. The persons who give primary oversight at these levels and the corresponding numbers of participating churches are as follows: Second Episcopal District (Bishop, approximately 368

churches), District Conference (Presiding Elder, 30-45 churches) and Local Church (Pastor, one church, except for circuits with two or more churches per pastor).[13] Participants' past attendance at a Health or HIV/AIDS Presentation/Workshop was assessed by three survey questions: 1) attendance at a health presentation/workshop, 2) attendance at an HIV/AIDS presentation/workshop, and 3) attendance and location of HIV/AIDS workshop if ever attended one (implication anywhere and not just the AME Church).

Extent Members Ever Attended A *Health* Presentation or Workshop

Survey Question Three asked participants, "Have you ever attended a health presentation or workshop at a:

a. Second Episcopal District Event (e.g., Founders' Day)

b. Local Church

c. District Conference

In this three-part question, 281 (64.6%) reported that they had attended a health presentation/workshop at a Second Episcopal District event; 268 (68.2%) at the District Conference level; and 340 (79.4%) at the local church level. Frequencies for this question are provided in Table 13. This confirms the ministry researcher's first hypothesis that, "There will be greater attendance at HIV/AIDS presentations and workshops at the local church level than at the District Conference and Second Episcopal District levels of the AME Church."

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[13] Only one key Second Episcopal District level was omitted, the Annual Conference level. (See Chapter Six, "Recommendations" section for Areas for Further Research.) The Annual Conference level is also presided over by the Bishop and consists of all the churches in two or more Presiding Elders' District for an Annual Conference.

Table 13.
Summary of Attendance at Selected AME Church Meetings for a Health Presentation/Workshop (Survey Question 3)

		FREQUENCY		
	Location of Health Presentation/Workshop	**YES (Percent)**	**NO (Percent)**	**Total Valid (Percent)**
Valid	Second Episcopal District	281 (64.6%)	154 (35.4)	435 (100%)
	District Conference	268 (68.2%)	125 (31.8%)	393 (100%)
	Local Church	340 (79.4%)	87 (20.6%)	428 (100%)

Overall, for each of the AME levels, the majority of survey participants indicated that they had attended a health presentation or workshop. This in not a surprise since announcements, health screenings, health education exhibit booths occur often. General health presentations/workshops were expected to be a more likely occurrence than those for HIV/AIDS. As seen by the results for Question 4 (Table 14) and the related explanations that follow, this proved true for 2003 Midyear Meeting respondents. The rationale for this may be limitations in participant recall of specific health topics covered in sessions or fewer HIV/AIDS sessions were offered.

Significance Findings

Overall, there were no significant differences in attendance at health presentations and workshops by Annual Conference affiliation at any of the AME levels surveyed. A one-sample chi-square test was conducted to assess whether there were significant differences in participation in *Second Episcopal District* health presentations and workshops based on Annual Conference affiliation. The results of the test were *not*

significant, χ^2 (N=435) = 4.850, p = .303. The proportion of participants indicating that they participated in a Second Episcopal District workshop did not differ significantly across the Annual Conferences.

A one-sample chi-square test was conducted to assess whether there were significant differences in participation in *District Conference* health presentations and workshops based Annual Conference affiliation. The results of the test were *not* significant, χ^2 (N=393) = 4.745, p = .314. The proportion of participants indicating that they participated in a District Conference presentation or workshop did not differ significantly across the Annual Conferences.

A one-sample chi-square test was conducted to assess whether there were significant differences in participation in a *local church* health presentations and workshops based Annual Conference affiliation. The results of the test were *not* significant, χ^2 (N=428) = 7.644, p=.106. The proportion of participants indicating that they participated in a local church presentation or workshop did not differ significantly across the Annual Conferences.

Extent Members Ever Attended a *HIV/AIDS* Presentation or Workshop

Survey Question Four asked participants "Have you ever attended an HIV/AIDS presentation or workshop at a: Second Episcopal District Event (e.g., Founders' Day), local Church or District Conference?"[14] In this three-part question, 170 (40.2%) reported

[14] Note: On the survey instrument used, the order of survey question components was varied from the typical AME Church structure. On the survey, the Second Episcopal District was listed, followed by the local church and the District Conference. Typically, the largest jurisdiction is listed first (i.e., the Second Episcopal District), followed by three other levels – Annual Conference, District Conference, local church. As stated later as a limitation, the addition of an Annual Conference question would have been helpful.

that they had attended a HIV/AIDS presentation/workshop at a Second Episcopal District event; 152 (41.3%) at the District Conference level; and 229 (55.7%) at the local church level. Frequencies for this question are provided below in Table 14.

Table 14.
Summary of Attendance at Selected AME Church Meetings for a HIV/AIDS Presentation/Workshop (Question 4)

		FREQUENCY		
	Location of HIV/AIDS Presentation/Workshop	**YES (Percent)**	**NO (Percent)**	**Total Valid (Percent)**
Valid	Second Episcopal District	170 (40.2%)	253 (59.8%)	423 (100%)
	District Conference	152 (41.3%)	216 (58.7%)	368 (100%)
	Local Church	229 (55.7%)	182 (44.3%)	411 (100%)

Significance Findings

Overall, there were no significant differences in attendance at HIV/AIDS presentations and workshops by Annual Conference affiliation at any AME level surveyed. A one-sample chi-square test was conducted to assess whether there were significant differences in participation in *Second Episcopal District* HIV/AIDS presentations and workshops based Annual Conference affiliation. The results of the test were *not* significant, χ^2 (N=423) = 1.637, p = .802. The proportion of participants indicating that they participated in a Second Episcopal District HIV/AIDS presentation or workshop did not differ significantly across the Annual Conferences.

A one-sample chi-square test was conducted to assess whether there were significant differences in participation in *District Conference* HIV/AIDS presentations and workshops based Annual Conference affiliation. The results of the test were *not* significant, χ^2 (N=368) = 3.146, p = .534. The proportion of participants indicating that they participated in a District Conference HIV/AIDS presentation or workshop did not differ significantly across the Annual Conferences.

A one-sample chi-square test was conducted to assess whether there were significant differences in participation in a *local church* HIV/AIDS presentations and workshops based Annual Conference affiliation. The results of the test were *not* significant, χ^2 (N=411) = 11.827, p=.159. The proportion of participants indicating that they participated in a local church HIV/AIDS presentation or workshop did not differ significantly across the Annual Conferences.

Location and Time Frame of HIV/AIDS Workshop If Ever Attended One

Survey Question Five asked participants, "Have you ever attended an HIV/AIDS presentation or workshop, if yes when and where?" The results are divided into three parts. As recorded in Table 15 (for the first part of question), the majority of persons (284 or 60.5%) had *ever* participated in an HIV/AIDS presentation/workshop in any setting. This is in sharp contrast to Question 4 above, which only asked about participation in three levels of AME meetings (and had a lower affirmative response).

Table 15.

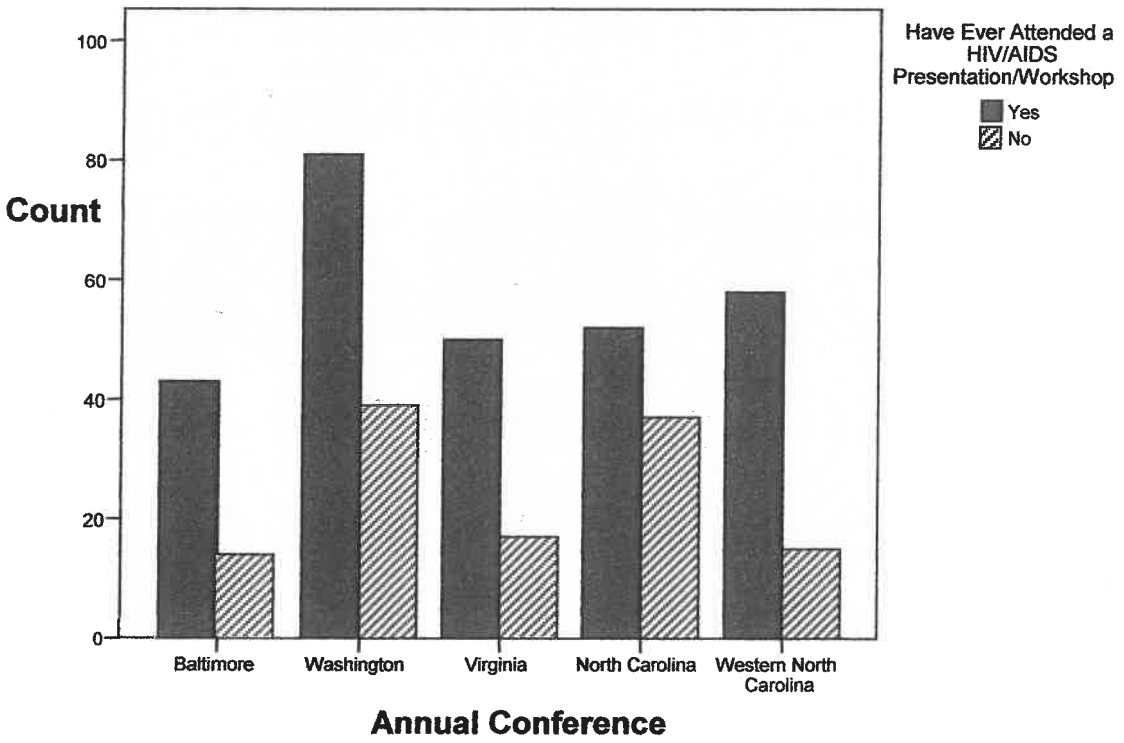
Summary of Past Attendance at An HIV/AIDS Presentation/Workshop (Question 5)

	Frequency		
	YES (Percent)	**NO (Percent)**	**Total Valid (Percent)**
Valid	284 (70%)	122 (30%)	406 (100%)

Significance Findings

A one-sample chi-square test was conducted to assess whether there were significant differences in persons who ever attended an HIV/AIDS presentations and workshops in any setting as it relates to Annual Conference affiliation. The results of the test *were* significant, χ^2 (N=406) = 10.615, p = .031. The proportion of participants indicating that they had ever participated in a HIV/AIDS presentation or workshop did strongly correlate to the Annual Conference affiliation. Figure 7 reveals results for this question as a bar chart.

Figure 7.
Persons Who Ever Attended an HIV/AIDS Presentation or Workshop By Annual Conference Bar Graph



Other Frequency Data on Persons Who Had Ever Attended an HIV/AIDS Workshop

The second part of Survey Question Five asked about when participation in an HIV/AIDS presentation/workshop occurred. The majority of persons did *not* answer the question (318 or 67.5% of the 471 persons sampled). Of those that did respond, 37 persons (7.9%) said they had attended in 2003 (the year survey was administered); 32 (6.8%) in the 1990s; 30 (6.4%) in 2002; 18 (3.8%) in 2001; 19 (4.0%) in 2000; and 13 (2.8%) said they attended a session annually.

Survey Question Five-B Limitations

The large number of non-respondents to this part of the question may imply that persons did not remember the specific time frame, since in the first part of the question, a majority of persons indicated that they had attended an HIV/AIDS presentation/workshop. Although limited by survey form space, a check in a box option may have helped increase the number of responses.

The third part of the question on past experience attending an HIV/AIDS presentation/workshop, asked where the event occurred. 51.8 % of persons responded to this question, while 227 or 48.2% did not. A summary of the top six responses is found in Table 16.[15]

Table 16.
Summary of Top Six Responses to Location of HIV/AIDS Presentation/Workshop Participants Ever Attended. (Question Five)

Location	Frequency	Percentage
Church	59	12.5%
City/State Given	50	10.6%
Any AME Level Other Than Local Church	39	8.3%
School/Educational Institution (Any Level)	27	5.7%
Job	27	5.7%
Any Health Agency (Any Level)	23	4.9%

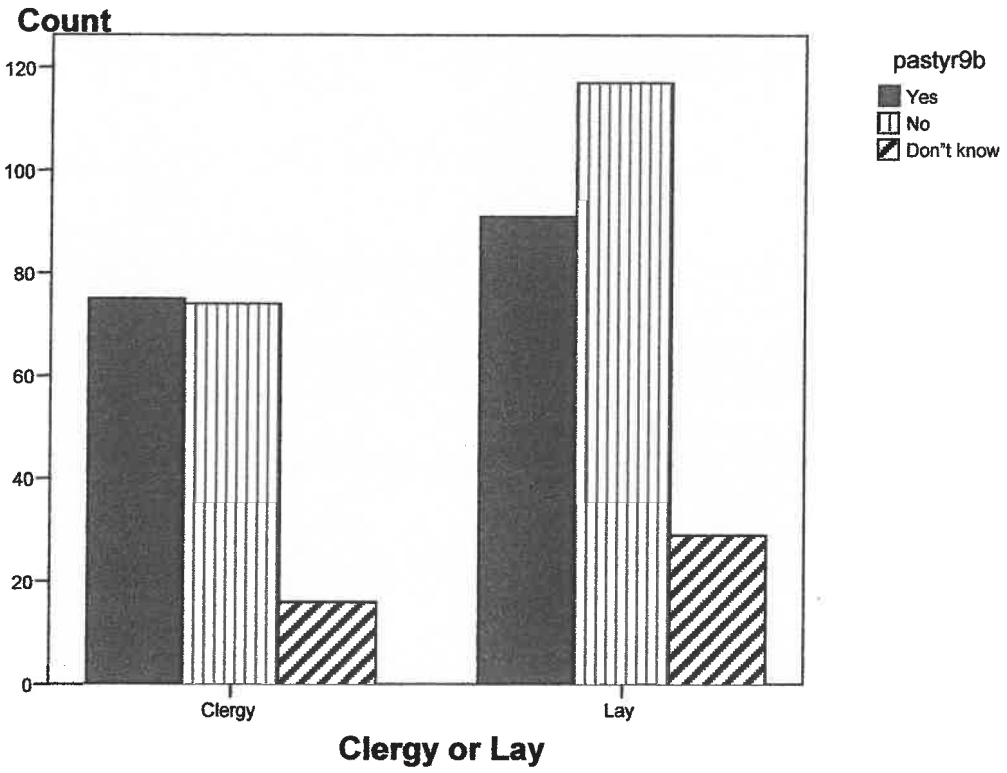
[15] See Appendix E for Selected Survey Data for additional graphs and charts.

Past Year You or Other Member of Clergy Discussed HIV/AIDS Risks with Members of the Congregation

An assessment of recent discussion on HIV/AIDS risks in the congregation was the primary purpose of Survey Question 9. The question asked "Within the past year have you or any other member of the clergy discussed the risks of HIV/AIDS with the church congregation?" Responses on the 471 surveys received were as follows: 180 persons (38.2%) said yes; 216 (45.9%) said no; and 47 (10.0%) said they don't know. Data was missing for 28 persons (5.9%). See Figure 8.

Overall, the majority of respondents did not indicate that HIV/AIDS risks had been discussed in the past year with their congregations. These responses should be considered in light of the last part of Survey Question Five, which asks when a person ever attended an HIV/AIDS presentation/workshop. Consistent with these results, very few persons indicated that they had attended in 2003 the same year the survey was administered or in 2002, the prior year. These results were 37 of the 471 persons surveyed (7.9%) for 2003; 29 (6.2%) for 2002; and 12 (2.5%) of persons indicated they had annual HIV/AIDS presentations/workshops. Nevertheless, as stated earlier, the majority of persons (318 or 67.5%) left this question blank.

Figure 8.
Past Year Discussion of HIV/AIDS Risks with Congregation Members Bar Graph



In addition, Survey Question Nine responses should be considered in light of other results: 1) Survey Question Four-b which asks whether the person has ever attended an HIV/AIDS presentation/workshop at a local church (231 persons of 471 surveyed or 49% said they had) and 2) Survey Question Five which asks when and where an HIV/AIDS presentation/workshop was ever attended (59 persons or 12.5% the of 471 indicated they had attended at a church, while only one person or 0.2% said other than a church event).

Survey Question Nine Limitations

Although the data provides insight, a clearer understanding of the response would have been obtained if the question was linked with Survey Question One-B on Clergy/Lay Status. Survey Question Nine may have been better rephrased to determine if anyone (regardless of clergy/lay status) had given a presentation in the past year. Use of the phrase "any clergy person" would have been preferred to "any *other* member of clergy" since the latter may imply that the respondent is also clergy.

Furthermore, a separate question regarding the respondents' own discussion of HIV/AIDS risk would have been clearer than coming at it with assessment of another's action. Also, the question asks whether discussion occurred with the "church congregation" which was intended to imply a public statement to the local church body. It is possible that some persons did not receive this message, and interpreted it to mean as any individual who had had a conversation about HIV/AIDS risks with someone in the church.

Quantitative Results for Research Question Two

The second research question was: what is the likelihood that members would support an HIV/AIDS church-based awareness project among African Americans and in Southern Africa as related to their annual conference affiliation. Research Question Two included quantitative and qualitative data to assess the readiness of the Second Episcopal District clergy leadership (i.e., Presiding Elders and Pastors) to address HIV/AIDS and related issues.

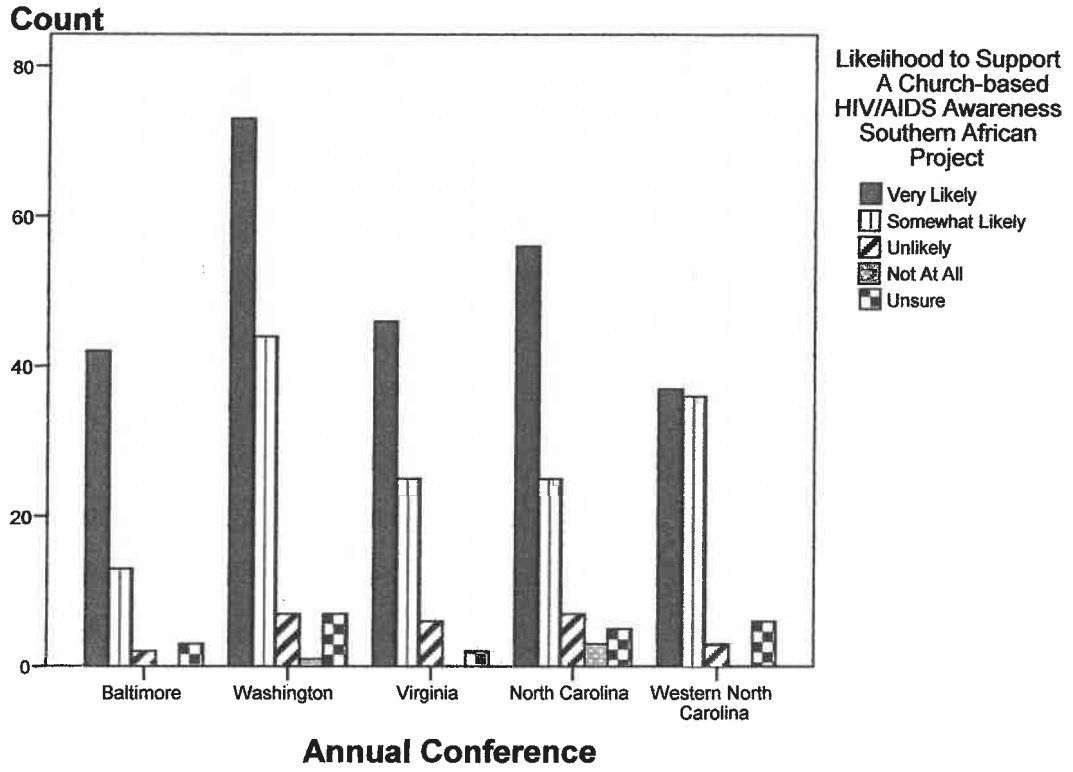
Likelihood to Support an HIV/AIDS Awareness Project Focused on African Americans or on Southern Africa

Survey Questions Seven and Eight sought to determine how open respondents were to supporting HIV/AIDS awareness projects, as further mobilization efforts continue. Survey Question Seven asked, "How likely is it that you would support an HIV/AIDS church-based awareness project focused on African Americans." Survey Question Eight did not specify church-based, but asked, "How likely is it that you would support an HIV/AIDS awareness project focused on Southern Africa?" In both cases the majority of respondents at the 2003 Midyear Meeting said that they were very likely to be supportive, 370 (78.6%) for African Americans and 253 (53.7%) for Southern Africa. When additional data is reviewed form persons "Somewhat" likely, those percentages of persons willing to support such projects rises to 442 (93.9%) for an African American project and for a Southern African project 397 (84.3%). There is sufficient evidence to suggest that constituents surveyed would be open to supporting further HIV/AIDS awareness projects, both domestic and international (in Southern Africa). See Table 17 and Figure 9 for frequency data. Future analysis will include significance findings.

Table 17.
Likelihood to Support An HIV/AIDS Church-based Project focused on *African Americans* or (Question 7)

Likelihood to Support An African American Project	Valid Frequency	Valid Percentage
Very Likely	370	80.0%
Somewhat Likely	72	16.0%
Unlikely	6	1.5%
Not At All	3	1.00%
Unsure	8	1.5%
Total	471	100%

Figure 9. Likelihood That Participants Would Support An HIV/AIDS Awareness Southern African Project (Question 8) Bar Graph



Supplemental Quantitative Results

There were two survey questions that provided supplemental data to Research Question One results. Survey Question Six addressed the types of literature reviewed by participants, and allows for increased understanding of where participants received HIV/AIDS educational information. Survey Question Ten addresses perceived modes

of HIV transmission. Only frequencies were generated for these two questions in contrast to frequencies *and* relationship data (chi-square) for items in Research Question pertaining to participants' Annual Conference affiliation.[16]

Types of HIV/AIDS Literature Ever Reviewed

Survey Question Six asked participants, "Have you ever reviewed any literature on HIV/AIDS?" Persons were asked to check all the responses that applied. As seen in Table 18, of the 471 persons surveyed, a majority had reviewed HIV/AIDS pamphlets (84.7%), fact sheets (55.8%) and brochures (69.9%) reviewed brochures. Only 31.6% had reviewed videos.

Table 18. Types of HIV/AIDS Literature Reviewed (Question Six)

Type	YES (Percentage)	MISSING/[NO][17] (Percentage)	TOTAL
Pamphlets	399 (84.7%)	72 (15.3%)	471 (100%)
Fact Sheets	263 (55.8%)	208 (44.1%)	471 (100%)
Brochures	329 (69.9%)	142 (30.1%)	471 (100%)
Videos	149 (31.6%)	322 (68.4%)	471 (100%)

[16] See Appendix E for the section entitled "Supplemental Quantitative Results." Additional crosstabs tables and bar charts are provided.

[17] The original intent of the Survey Question Six was that persons who did *not* place a check beside a given answer choice (i.e., they left it blank), would imply that that the person had not that type of literature (i.e., "no" response to that item being a received). Valid responses are those in which a question was answered by a noted response on the survey form (e.g., check mark or "x" was written). However, the "Missing" value column includes data not considered valid (i.e., where no check mark was placed for whatever reason). Thus, "missing" refers to those persons who either: a) skipped the answer choice (implied "no"), b) skipped the question entirely or c) had another answer choice in mind, and might have responded if given an "other" answer choice. See also the subsequent section on limitations in the design of the question.

Survey Question Six Limitations

Although the question on HIV/AIDS literature provides insights, there are some limitations with the results. First, it would have been helpful to allow for an "other" answer choice or to specify additional response options such as books, magazines, as well as other audiovisual materials such as DVDs. The impact of other media such as radio, television, films and billboards was not addressed, and should be considered in future work.

Knowledge of HIV/AIDS Transmission

The final survey question assessed how aware persons are of primary modes of transmission of HIV. Survey Question Ten asks participants to check all the responses that apply in the statement, "HIV/AIDS can be transmitted by: kissing, sexual contact, [intravenous] IV needle sharing, blood transfusions [and] toilet." The expected correct answers based on research and reports from Centers for Disease Control and Prevention (CDC) and the National Institutes of Health would exclude the choices for kissing and toilet.[18] Results are found on the next page in Table 19.[19]

Table 27 indicates that the majority of constituents could correctly identify proven modes of transmission of HIV. However, there is still work to be done in educating

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[18] One reference that supports this is a March 2007 National Institute of Allergy and Infectious Diseases Fact Sheet entitled "HIV Infection and AIDS: An Overview." On page two of the section on saliva, it states, "Research studies of people infected with HIV have found no evidence that the virus is spread through others through saliva by kissing. The lining of the mouth, however, can be infected by HIV, and instances of HIV transmission through oral intercourse have been reported. Scientists have found no evidence that HIV is spread through sweat, tears, urine, or feces."

[19] Also see Appendix E for Selected Survey Data.

persons as is evident by those 100 (21.2%) persons who indicated kissing and 28 (5.9%) who replied that the toilet were modes of transmission. On the original survey forms, some persons even wrote comments for these two choices indicating that it was an opinion or that they were not sure. Even while collecting the instrument, a respondent stated to a staff person that they were unsure of the answer to Survey Question Ten. This reflects a need for more specific HIV/AIDS awareness materials and training on modes of transmission for constituents.

Table 19. Perceptions on Possible Modes of HIV Transmission

Possible Mode of Transmission	YES (Percentage)	MISSING/[NO][20] (Percentage)	TOTAL
Kissing	100 (21.2%)	371 (78.8%)	471 (100%)
Sexual Contact	442 (93.8%)	29 (6.2%)	471 (100%)
IV Needle Sharing	437 (92.8%)	34 (7.2%)	471 (100%)
Blood Transfusions	438 (93%)	33 (7.0%)	471 (100%)
Toilet	28 (5.9%)	443 (94.1%)	471 (100%)

[20] The original intent of the Survey Question Ten is similar to that of Survey Question Six above, as related to a checked or a missing response on the completed surveys. Persons who did *not* place a check beside a given answer choice (i.e., they left it blank), would imply that that the person did not perceive that choice as a mode of transmission (i.e., "no" response to that item being a transmission mode). Valid responses are those in which a question was answered by a noted response on the survey form (e.g., check mark or "x" was written). However, the "Missing" value column includes data not considered valid (i.e., where no check mark was placed for whatever reason). "Missing" refers to those persons who either: a) skipped the answer choice (implied "no"), b) skipped the question entirely or c) had another answer choice in mind, and might have responded if given an "other" answer choice. See also the subsequent section on limitations in the design of the question.

Survey Question Ten Limitations

The question used "HIV/AIDS" and not "HIV" alone. A better wording for the question would have been "HIV is transmitted by…?" This would have had clearer meaning to actual fact that it is the virus that is transmitted, which can lead to the disease (AIDS). In addition, perhaps a qualifier such as "proven" methods of transmission would have been helpful for some respondents.

Finally, the design of the question limits interpretation of a missing answer. A missing answer may mean either the respondent skipped the question or did not agree that a given answer choice was a mode of HIV transmission. The question asked persons to check all answers that applied (and did not ask for yes/no response for each possible choice of transmission mode. Thus, it cannot be assumed that missing responses mean that respondents did not believe the answer choice were modes of HIV transmission. Despite the answer choice wording, some people may still be unaware and/or may have their own opinions regardless of the question's wording. For example, one respondent wrote next to one of transmission responses, "my opinion."

Qualitative Data Results for Research Question Three

Research Question Three included qualitative data to assess the readiness of various segments of the Second Episcopal District to address HIV/AIDS and related issues as perceived by selected leadership. Nine in-depth interviews were conducted with Pastors, Presiding Elders, the Episcopal Supervisor and the Presiding Bishop of the Second Episcopal District:

- One interview with the Presiding Bishop of the Second Episcopal District
- One interview with the Episcopal Supervisor of the Women's Missionary Society, Young People's Division and Clergy Families Organization
- Five interviews with Presiding Elders who each oversee 30-45 churches (Baltimore, Washington DC, Virginia, North Carolina and Western North Carolina Annual Conferences)
- Two interviews with Pastors of local churches – (Washington DC and Western North Carolina Annual Conferences)

This section contains selected results from the nine in-depth interviews and are categorized by the Challenges, Opportunities, Readiness and Education (CORE).[21] A diversity of responses was received in all CORE categories. Overall, there is openness to conducting HIV/AIDS awareness activities, with a realistic understanding of the challenges facing such action. Future plans include: a) further analysis of the nine interviews in this ministry project, b) conduct of additional interviews with Pastors from other Annual Conferences and other segments of the Second Episcopal District (especially the laity and youth) and c) development of case studies.[22]

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[21] Sample instruments are found in Appendix D. Selected transcripts are in Appendix F. Transcriptions may have been modified slightly to maintain confidentiality of the in-depth interview participants. Interviews were transcribed by an independent company without knowledge of specific interviewees. Transcriptions should be viewed in light of colloquial intent, with minimal attention to grammatical errors and any other unclear areas.

[22] See Chapter Six for "Areas for Further Research."

Challenges

Interview Question: What do you think the major challenges are to HIV/AIDS awareness projects in your local church/District/Episcopal District?

Sample Entry One

P: The challenges are where do I get the proper information and the people power to do that. In other words, if I take it on myself, that means I neglect something else or, you know, I have to spread myself around so many different places as a pastor that it would take somebody. I would need someone else to help me do it.

P: Another challenge would be getting people to open up to, you know, to even get it out there, to make people comfortable enough to talk about it. The atmosphere is a challenge, and I think that really having someone to team with the pastor or with somebody in the congregation to do it because what I'm seeing just as a pastor I'm seeing that a lot of the times. How to say? My situation being a young pastor, the older generation doesn't always take what I say because I'm younger, so having someone with the statistics to back up the pastor or whoever it is presenting the information it's definitely needed.

Not only the age difference, but if somebody in the congregation presents the material you have people looking at them saying, "well how do they know and where did they get that information from." So you have to, on a spiritual tip, you have to steer (inaudible) warfare to get the information out to the people. And I think having somebody with experience who already knows all of the preconceived thoughts that we have about HIV

and AIDS or the misinformation that we have already. We have to combat the [disease] because a lot of people have been misinformed or they've come to their own information.

Sample Entry Three

P: That's a good question, at this particular moment the challenge there would be to [identify] someone to inspire or to boast [boost] or to edge (not just a pastor) but the people into taking more consideration into the AIDS program, about AIDS. They need to be boosted. I don't know [interviewer referenced], if you will allow me to say that.
P: It just seems that folk are taking AIDS as something just passing by, as just another name. They don't seem to be wrapped up in this thing like maybe cancer or gonorrhea or syphilis even. They don't seem to be taking AIDS as if it were AIDS or HIV and then gone, you understand what I'm saying?
P: It's not an interest there, in the community.

Opportunities

Interview Question: What do you think the major opportunities are to implement-ing an HIV/AIDS awareness project in your local church/District/Episcopal District?

Sample Entry One

P: I would say Connectional wise, it's really getting out coming to the forefront. In our last pick-up meeting we had before Founders' Day, it was asked could we do a workshop at our Easter conference and allow the people, (I'm not certain who the group was, but it was concerning HIV/AIDS), to come in and do a workshop a brief, probably about an

hour long. It's a segment of the various workshops that we'll have. To be honest I had a lot of support from the peers. I had a lot of people saying, "Yes, we really need this," but leadership wise, it was felt that other things needed to be addressed. So that's the only connection, I am a part of that on the local setting.

P: For the district conference level. That's the atmosphere concerning HIV and AIDS at the district conference level that there are more prevalent things, now what those prevalent things are I don't know, but that's the things that we heard. And the local level, myself as a pastor, I have been at this church for about XXX months.[23] I would say I wouldn't have too much of a problem doing health awareness, HIV/AIDS awareness because I'm for it but I think that's an individual thing. There's not a lot of, there's not a support system as far as the local churches are concerned. Where we would readily get information we would have to hunt. We would have to go get it oursel[ves], [which] some would do, but most would not because of the scheduling, timing and all that kind of stuff.

P: Also having the resources, having the people power to get that information.

P: Because of what's going on in his church and he's saying basically being in the community that the church is in, and really all of our churches are in the heart of the community basically. And he's having to address these issues and he thought it would be a good thing to have someone come in on the district level and address it to the District Conference.

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[23] As mentioned above, identifiers (e.g., number of months) have been masked (i.e., XXX) to ensure confidentiality

Sample Entry Three

P: The opportunity in my district, I would say most, [is] the major part of my district is rural setting. The opportunity there for someone to come in and do an AIDS project would be great because of the setting there. It's not like the city environment and so they don't have box minded to the nature of things in the rural as they do in the city. So I think it's a great opportunity there.

Readiness

Interview Question: On a scale of one to five where one is low and five is high how would you rate the overall readiness of the local church you pastor [or district you serve as presiding elder] to address HIV/AIDS?

Sample Entry One

P: I would say the readiness of the church is probably "one." I would say one. The people need to be educated concerning HIV before they would even be ready to get that information out to the community, but the body itself would need the education. I just believe that people don't really know what it is to deal with HIV and AIDS.

Sample Entry Two

P: I would rate it a five. And the reason is we have had at least two sessions or two presentations in the past since I've been a presiding elder and interest seemed very high and people seemed very receptive and they attended the sessions well.

Sample Entry Three

P: I would say, I would go in between, three.

P: Yes because truthfully I don't see too many conversations pertaining to AIDS and I'm a little disturbed about it on the district.

P: [disturbed] about how they're responding to AIDS, the seriousness of AIDS, I don't see too many pastors…they seem lackadaisical they don't seem like they're with it too much.

Education

Interview Question: How open are you in your position as Pastor/Presiding Elder/Episcopal Leader to help raise awareness on HIV/AIDS? What could be done to assist you?

Sample Entry One

P: I am very open, very open because I know that it is something that's going to creep up on the church at an alarming rate.

P: Actually the thing that I said, the support is really the main thing, because I know that our family that know of someone in their family, maybe even if it's extended family, that's HIV positive, so it would not be that I have any hang up telling them the information or getting it to them or providing the forum for it. But the support is more or less what I would need as a pastor.

Sample Entry Four

P: I guess identification of resources, and a resource person who would be available to conduct a session and do follow-up with the various congregations. [This is] primarily a resource problem that I'm concerned with. That would be my issue.

In-depth Interview Summary

Preliminary analysis of in-depth interview data reveals that in relation to the CORE elements, there is diversity among the key leaders in terms of the readiness and what is needed to raise HIV prevention and care activities in the AME community. Rural versus urban needs as well as the tenure and age of leadership were among the many factors that need to be addressed. There was also revealed a need for resources, including speakers and materials.

Research Question Three asks, "What is the perceived extent of readiness, opportunities and challenges of the Second Episcopal District to address HIV/AIDS and related issues as determined by in-depth interviews with selected leadership including: the Bishop, Episcopal Supervisor, Presiding Elders and Pastors?" In Hypothesis Three, the ministry researcher proposed that the Second Episcopal District would be perceived as ready to address HIV/AIDS issues, given adequate training and other support services. The results of qualitative data to support this hypothesis are not conclusive, and further study is needed to assess the readiness. There seems to be, however, some agreement that additional training and support would assist mobilization efforts. Quantitative data demonstrates that there is a majority of valid respondents to the survey who indicated an

interest in supporting an HIV/AIDS project focused on African Americans and Southern Africa.

Mobilization Efforts

Several items were developed to assist congregations in promoting HIV/AIDS awareness. Figure 10 summarizes various mobilization activities according to the SHINE Global Model. Key items produced include the following: HIV/AIDS Action Alerts, the 2004-2005 HIV/AIDS Awareness Action Packets, and the DVD entitled, *Second Episcopal District, African Methodist Episcopal Church HIV/AIDS Awareness: A Call to Action*. In addition, materials were disseminated and events occurred to support national HIV/AIDS awareness days, culminating in World AIDS Day observances. As mentioned previously, the ministry researcher served as the Program Director for the PCOC project funded by the United States Department of Health and Human Services, Office of Minority Health. The results of key mobilization efforts are described in the sections that follow.

Figure 10.

SHINE Focal Area Summary of Mobilization Activities Conducted in the Second Episcopal District 2003-2004

SHINE Focal Area	Examples of Mobilization Activities
Spiritual Growth and Maturity	✝ Bishop and Episcopal Supervisor's Public Statements to the Members of the Second Episcopal District Meetings, including call for churches and component organizations to conduct World AIDS Day events ✝ Conduct of World AIDS Day Worship Services ✝ Dissemination of Sample Litany for HIV/AIDS Awareness Worship Services
Health and Wholeness	*Prevention Materials:* ✝ HIV/AIDS Educational Materials: - 2004-2005 HIV/AIDS Awareness Action Packet - *HIV/AIDS Awareness: A Call to Action* DVD - HIV/AIDS Action Alerts - HIV/AIDS Awareness Displays - Press Conference which included HIV/AIDS as a Focal Point *Prevention Activities:* ✝ HIV/AIDS presentations at the Second Episcopal District, District Conferences and Local Churches Meetings ✝ HIV Testing
Insight	✝ Lessons Learned and Recommendations Generated ✝ DVD and additional footage of Second Episcopal District Constituents Discussing Various HIV/AIDS issues
Networking	Collaboration with/between: ✝ Local AME Churches in the Second Episcopal District ✝ Second District Religious, Educational and Charitable Development Projects, Inc. ✝ Non-profit Organizations Affiliated with Local AME Churches such as: - Pilgrim Community Outreach Corporation - Richard Allen Community Development Corporation ✝ U.S. Department of Health and Human Services: 1) Office of Minority Health and 2) Deputy Secretary's Office ✝ Local Health Departments: - North Carolina Health Department, Prevention and Community Planning Unit (Presentation at Second District Lay Convention) - District of Columbia Department of Health, HIV/AIDS Administration (DC owned HIV Testing Van after Pilgrim AME Church's World AIDS Day Service)
Empowerment	✝ Initial Planning with the Second Episcopal District Lay Organization for Ongoing Work with Its Health and Wellness Committees

HIV/AIDS Action Alerts

Action Alerts were periodic documents created to provide constituents with updates to assist in their participation in national 2004 HIV/AIDS Awareness Days. Alerts were designed to be brief and easy to duplicate in local church settings. Examples of awareness days in which Action Alerts were geared include: the National African American HIV Awareness Day (February 2004), Black Church Week of Prayer for the Healing of AIDS (March 7-13, 2004), HIV Testing Day[24] (June 27, 2004) and World AIDS Day (December 1, 2004).

Action Alerts were mailed to approximately 142 churches in the Baltimore and Washington DC Annual Conferences, to encourage support of the Black Church Week of Prayer for the Healing of AIDS (February-March 2004).

Approximately 4,650 Action Alerts were disseminated at the following meetings:

1. Southern District Conference of the North Carolina Annual Conference, Mt. Calvary AME Church, Navassa, North Carolina (March 2004)
2. Baltimore Annual Conference, Waters AME Church, Baltimore, Maryland (April 2004)
3. Washington DC Annual Conference, Hylton Memorial Chapel, Woodbridge, Virginia (April 2004)
4. Virginia Annual Conference, Courtyard Marriott – Norfolk Downtown, Norfolk, Virginia (May 2004)

[24] HIV Testing Day gained national attention as CDC released data to suggest that there were approximately 250,000 people infected with HIV who were unaware of their status. In this project, the District of Columbia provided free HIV testing in its van in December 2004 to support Pilgrim AME Church's World AIDS Day Worship Service.

5. North Carolina Annual Conference, Holiday Inn, Fayetteville, North Carolina (May 2004)
6. Western North Carolina Annual Conference, Sheraton Four Points and Koury Convention Center, Greensboro, North Carolina (June 2004)
7. Second Episcopal District Agape Fest at Ebenezer AME Church, Fort Washington, Maryland (June 2004)
8. Midyear Meeting, North Raleigh Hilton Hotel, St. Paul AME Church (Host Church), Raleigh, North Carolina (October 2004)
9. Second Episcopal District Lay Organization Convention held at the Sheraton Atlantic Beach, Atlantic Beach, North Carolina (November 2004)

In most of the venues above, a brief presentation was given by the ministry researcher, and a display booth was set up by project staff. Episcopal District leaders also emphasized the importance of raising HIV/AIDS awareness in the African American community. Leading these efforts during this project period were: Bishop Vinton R. Anderson (former Presiding Bishop); Bishop Adam J. Richardson, Jr. (current Presiding Bishop); Mrs. Connie Speights Richardson (current Episcopal Supervisor for the Women's Missionary Society, Young People's Division and Clergy Families Organization); and Dr. Cellestine Cheeks (President, Second Episcopal District Lay Organization).[25]

[25]As stated previously, this ministry project spanned two administrations of the Second Episcopal District and Second District RED, Inc. Bishop Anderson's second and last term as presiding prelate before his retirement was July 2000 – mid - July 2004. Bishop and Mrs. Richardson's terms started mid-July 2004 through present. The Episcopal Supervisor's term typically coincides with the Bishop's term. Typically, each term is four years.

2004-2005 HIV/AIDS Awareness Action Packets

These packets were developed to assist in mobilizing congregations to increase expressions of compassion to infected persons and families who are affected. More specifically, the HIV/AIDS Awareness Action Packet served as a resource guide for celebration of World AIDS Day 2004.[26] This packet was inspired by collaboration with Bishop and Mrs. Richardson. Content included:

a. A Cover Letter from the Presiding Bishop and Episcopal Supervisor of the Second Episcopal District, AME Church;

b. HIV/AIDS Fact Sheets;

c. Council of Bishops' Statement on HIV/AIDS (2002);

d. Liturgical Materials for HIV/AIDS Awareness Services;

e. An Overview of Results for the HIV/AIDS Survey Conducted at the 2003 Midyear Meeting;

f. Action Alert for World AIDS Day, December 1, 2004; and

g. Supplemental HIV/AIDS information on statistical data and other facts, organized according to geographical areas of the Annual Conferences in the Second Episcopal District (i.e., "HIV/AIDS Among African Americans," "General HIV/AIDS Information," and statistics and related articles for Maryland, District of Columbia, Virginia and North Carolina.[27]

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[26] Further elaboration on dissemination outcomes is found in the later section on World AIDS Day.

[27] See Appendix G for a sample of contents in the 2004-2005 HIV/ADS Awareness Action Packet.

From October – November 2004, 500 Action Packets were disseminated to pastors and lay leaders of the Second Episcopal District at the following: 1) Midyear Meeting in Raleigh, North Carolina; 2) 10th Annual Second Episcopal District Lay Organization Convention in Atlantic Beach, North Carolina; and 3) the Capitol District Conference, Washington Annual Conference.

Second Episcopal District, AME Church
HIV/AIDS Awareness: A Call to Action DVD

Beginning in August 2004, planning and initial taping for the DVD to be used for HIV/AIDS outreach purposes within the Second District began with the ministry researcher and PCOC staff, in consultation with the Episcopal leadership, Bishop Adam J. Richardson, Jr. and Mrs. Connie S. Richardson. Inspiration for use of the DVD as a preferred medium and related technical assistance was provided by Urban World Productions - Las Vegas, with the Reverend Keith E. Andrews, II, Executive Producer. In addition, the Reverend Maria Mallory White of Florida A & M School of Journalism, Media and Graphic Arts, gave leadership to a segment of the DVD taped in Florida. Overall, AME clergy and lay leaders (including nurses, a physician, and public health professionals), as well as youth and university faculty were interviewed.

The DVD for the project was entitled, *HIV/AIDS Awareness: A Call to Action.* Featured on this DVD were: Bishop and Mrs. Richardson and a colleague from Florida A & M University, Dr. John W. Chambers, Department of Psychology. The interviewer

for this segment was the Reverend Maria Mallory White. Lessons learned were discussed by sharing: a) HIV/AIDS prevention and research on the AME Church awareness work done on the African continent (particularly the Nineteenth Episcopal District in South Africa) and b) mobilization plans for the Second Episcopal District.

In addition, Rev. Lucille Norville-Perez, M.D., past president of the National Medical Association and AME minister, provided a medical perspective when interviewed by the Reverend Keith Andrews. Five hundred DVDs were released at the closing session of Founders' Day in Washington DC and subsequent outreach events. The significance of the release of the tapes during this celebration was to remind the participants that Richard Allen, an AME founder, and others were instrumental in assisting persons during the yellow fever epidemic in 1793 in Philadelphia. Constituents were urged to do likewise for the HIV/AIDS pandemic.[28] DVD copies were available for Second District RED Board Members, as well as one copy per church.[29]

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[28] For additional information on the AME response to the yellow fever epidemic, refer to Chapter Three, "Historical Foundation" and the section on the "Overview of AME Church History in Social Action and Health Promotion."

[29] See Appendix H for a copy of the DVD and the cover letter entitled "A Message from the Bishop and Episcopal Supervisor," as well as for lessons learned. Additional footage is available for future DVDs and for historical reference. For example, resources include the speech by former Deputy Secretary of Health and Human Services, the Honorable Claude Allen, and taping of youth, Second Episcopal District officers and other church leaders.

HIV/AIDS Awareness Activities to Support National Health Awareness Days

Black Church Week of Prayer for the Healing of AIDS (March 7-13, 2004)

As noted in an earlier section on the Action Alerts for the *Black Church Week of Prayer for the Healing of AIDS* was distributed to churches in the Second Episcopal District, including a mailing to churches in the Baltimore and Washington DC Annual Conferences.[30] The Action Alert gave a brief description of the purpose of the *Black Church Week of Prayer for the Healing of AIDS,* the effects of the disease among African Americans and among the African Diaspora, and suggestions for making AIDS education a component of a church's worship experience. The Overview of the Pilgrim Community Outreach HIV/AIDS Series for Member Denomination Project (a handout) was disseminated along with the Action Alert.[31]

The ministry researcher conducted an HIV/AIDS workshop at the Southern District Conference of the North Carolina Annual Conference (March 2004). Awareness materials, including Action Alerts and HIV/AIDS surveys, were disseminated. The presentation was done at the request of a RED Board member, Presiding Elder Evelyn Dunn, who gives leadership to the Southern District, which is comprised of 42 churches. More than 150 persons were present for the workshop.[32]

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[30] This awareness day is sponsored by the Balm in Gilead, Inc. in New York, New York, and has been traditionally supported by faith-based institutions worldwide, including the AME Church.

[31] See Appendix H for a copy of the Action Alert and the project overview handout.

[32] As mentioned earlier, sixty-nine HIV/AIDS Surveys were collected for later analysis.

National HIV Testing Day (June 26, 2004) and Overall Health Awareness Efforts (April – June 2004)

The late Reverend Karen Young, PCOC Program Manager, led efforts to communicate with Second District constituents through exhibit booths at each Annual Conference: Baltimore, Washington DC, Virginia, North Carolina and Western North Carolina. Although the total number of persons who visited booths was not recorded (since all did not sign-in), on average at least 300 persons per Annual Conference were reached through materials distributed at the booth and/or related dissemination during the meeting. In some cases, more persons were reached through presentations made to the conference participants (e.g., North Carolina and Western North Carolina), and through representatives who agreed to take information back to their local churches and communities.[33]

In addition to attending the above Annual Conference exhibits, the ministry researcher made a presentation and disseminated materials as a part of the Social Action and Community Action Committee Reports of the North Carolina and Western North Carolina Annual Conferences (May – June 2004). Resolutions were passed in both Annual Conferences to support continued HIV/AIDS activities. It should also be noted that as a part of observations made during the conferences, information was collected on churches engaged in health activities, as noted in the pastors' reports. This information is helpful for follow-up efforts.

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[33] See Appendix H for sample projects overview and North Carolina presentation handouts.

World AIDS Day (December 1, 2004)

The kick-off for World AIDS Day activities throughout the Second Episcopal District occurred at the 2004 Midyear Meeting in Raleigh, North Carolina. A call to action by Bishop and Mrs. Richardson, was given along with resource materials to support the work of local congregations and individuals.[34] A summary of steps is provided to: a) help prepare churches for participation and b) conduct prevention activities which are provided in the next sections.

Preparation for World AIDS Day 2004

The ministry researcher gave an overview of the project to the Executive Board of the Second Episcopal District Lay Organization at its meeting in Richmond, Virginia (August 2004). The invitation was extended by the President, Dr. Cellestine Cheeks. The purpose was to give an appeal to lay leaders for further participation, and to provide an overview of plans for HIV/AIDS mobilization efforts in the five Annual Conferences (i.e., Baltimore, Washington DC, Virginia, North Carolina and Western North Carolina).

Bishop Adam J. Richardson, Jr. unveiled his Seven-Point Agenda for the Second Episcopal District at the August 2004 Planning Meeting in Portsmouth, Virginia. The Episcopal-district wide focus on "Health and Personal Development" set the stage for further work in HIV/AIDS.

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[34] See earlier sections for information on the 2004-2005 HIV/AIDS Awareness Action Packet and the *HIV/AIDS Awareness: A Call to Action* DVD.

Continued collaboration (including submission of reports) to the Second District RED, Inc. Board of Directors occurred at the October 25, 2004 meeting in Raleigh, North Carolina. An overview of progress for the project was given, as well as a preview and plans for release of the 2004-2005 HIV/AIDS Awareness Action Packet at the 2004 Midyear Meeting.[35]

HIV/AIDS awareness was a key focus at the closing session of the Second Episcopal District 2004 Midyear Meeting on October 26 - 28, 2004 in Raleigh, North Carolina. Thanks to the Director of the Office of Minority Health, the Honorable Claude Allen, Deputy Secretary, U.S. Department of Health and Human Services, was secured as a speaker. The Deputy Secretary delivered a thought-provoking speech to help highlight the importance of HIV/AIDS education and awareness in communities in the United States and in Africa. The presentation was well received, and was followed by the historic release of the 2004-2005 HIV/AIDS Awareness Action Packets. The speech was videotaped (and photographs) were added to the HIV/AIDS resource tools for the Second Episcopal District.

The ministry researcher was invited to do another presentation to constituents as a follow-up to the previously mentioned August 2004 Executive Board meeting of the Second Episcopal District Lay Organization and the October 2004 Midyear Meeting. The presentation was given during the Tenth Second Episcopal District Lay Organization

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[35] See Appendix G for a sample of Second District RED Board reports. Appendix H contains an article in *The 2nd Epistle* newspaper and other items related to this event.

Biennial Convention held on November 4-6, 2006 in Atlantic Beach, North Carolina. Special thanks and appreciation were extended to Dr. Cellestine Cheeks (Second District President) and each of the Annual Conference Lay Organization Presidents and other members for their tremendous support.

The ministry researcher was a part of an HIV/AIDS panel at the "President's Luncheon" at the above convention, and gave a fifteen minute presentation on the *Pilgrim Community Outreach HIV/AIDS Series for Member Denomination* Project including an appeal for greater participation. Over 300 of the 2004-2005 HIV/AIDS Awareness Action Packets were distributed to the Lay Organization presidents and member represented at the convention. The Presidents were asked to utilize the packets in any way that would benefit their churches. They were requested to use content in part or in its entirety. Another panel presenter was from the North Carolina Prevention and Care Branch spoke on HIV/AIDS from the theme, "Wake Up Everybody."

The Capitol District of the Washington Annual Conference (which consists of 41 churches and their related non-profit organizations) distributed the 2004-2005 HIV/AIDS Awareness Action Packets at its meeting at Ward AME Church in Washington DC (November 2004). This was a follow-up to dissemination efforts at the 2004 Midyear Meeting in Raleigh, NC and 10th Annual Second Episcopal District Lay Convention in Atlantic Beach, NC. The ministry researcher also gave a presentation as a part of the Committee on Health Education's workshop.

Conduct of Prevention Activities to Support World AIDS Day 2004

Examples of activities conducted include the conduct of worship services and prayer meetings, HIV testing, workshops, presentations to constituents and dissemination of awareness materials. Churches throughout the Second Episcopal District observed "World AIDS Day." In this section some of the activities conducted by churches in the Baltimore, Washington DC and Western North Carolina Annual Conferences are described.

- Pilgrim AME Church in Washington DC held World AIDS Day activities which included: distribution of HIV/AIDS awareness ribbons, a noonday worship service in recognition of HIV/AIDS prevention and care needs in the nation's capitol, educational resources and free testing HIV testing sponsored by the District of Columbia Health Department on its Traveling Van Service.
- Greater Mt. Nebo AME Church in Bowie, Maryland sponsored a mailing of selected HIV/AIDS materials to approximately 80 churches in the Washington DC metropolitan area.
- The ministry researcher spoke at the Worlds AIDS Day Service for the community sponsored by Bethel AME Church in Baltimore, Maryland. Bethel Baltimore also sponsored a mailing campaign.[36]
- Bethel AME Church in Greensboro, North Carolina held a World AIDS

[36] See Appendix H for a coy of this World AIDS Day Service program.

Day worship service and to raise awareness on HIV/AIDS in conjunction with other local churches and concerned residents.

CHAPTER SIX

SUMMARY, REFLECTIONS AND CONCLUSION

The *SHINE Global Model for Second Episcopal District Mobilization for Prevention And Care Efforts Using Government and Faith-based Initiatives* was developed in response to the ongoing need for churches to address the pressing concerns of the people they serve. The model is based on the ministry researcher's health and theological background, as well as relevant experiences in the United States and Southern Africa. The project was conducted in the Second Episcopal District (mid-Atlantic region) of the African Methodist Episcopal Church which comprises five Annual Conferences: Baltimore, Washington DC, Virginia, North Carolina and Western North Carolina. Research collaboration occurred with the Second District Religious, Educational and Charitable Development Projects, Inc. (RED) and the Pilgrim Community Outreach Corporation (PCOC). A grant from the Office of Minority Health under the U.S. Department of Health and Human Services (Cooperative Agreement Number - US2MP03002) provided partial support to the ministry researcher's project work.

This chapter includes three major parts: 1) a summary of quantitative and qualitative results; 2) reflection on the lessons learned from the SHINE Model - Phase I (Mobilization), and implications for replicating such as capacity-building, implementation and areas for further research; and 3) a concluding theological reflection on the overall ministry project.

Summary of Results

This section provides a summary of results to all three research questions for the *SHINE Global Model for Second Episcopal District Mobilization for Prevention And Care Efforts Using Government and Faith-based Initiatives.* The three research questions in this ministry project all pertained to members of the Second Episcopal District of the AME Church. A mixed method design was used, consisting of quantitative and qualitative methodologies. Research Question One and Research Two considered quantitative data as related to participants' Annual Conference affiliation. This data was compiled from the 2003 HIV/AIDS Survey conducted at a Second District RED, Inc. Board Meeting and the Midyear Conference held in Raleigh, North Carolina. In addition, supplemental quantitative data results are shared that provide insight to educational needs of Second Episcopal District constituents. Research Question Three primarily involved qualitative data (e.g., interviews) on key leaders' perspectives on the challenges, opportunities, readiness and educational needs (CORE) for enhancing HIV/AIDS prevention and care mobilization efforts. This qualitative data provided insights on related quantitative (survey) data.

Research Question One

Research Question One explored to what extent members: 1) attended a health and/or HIV/AIDS presentation or workshop at selected AME Meetings; 2) ever attended a HIV/AIDS presentation or workshop (in any setting and when it occurred); and 3) shared or heard a clergyperson discuss HIV/AIDS with the church congregation.

Attended a Health and/or HIV/AIDS Presentation or Workshop at Selected AME Meetings

Health Presentation or Workshop

Overall, there were no significant differences in attendance at health presentations and workshops by Annual Conference affiliation at any AME levels surveyed including: Second Episcopal District, District Conference, and the local church. A one-sample chi-square test was used to determine significance at each AME Church level. In order to denote significant relationships between variables, whenever $p<.05$, a significance was recorded for the chi-square test. The value for the Second Episcopal District was $p=.303$, for the District Conference, $p=.314$, and for the local church, $p=.106$.

Of the 471 participants in the Midyear Conference survey, valid data indicated: 281 (64.6%) reported that they had attended a health presentation/workshop at a Second Episcopal District event; 268 (68.2%) at the District Conference level; and 340 (79.4%) at the local church level.

HIV/AIDS Presentation or Workshop

Overall, there were no significant differences in attendance at HIV/AIDS presentations and workshops by Annual Conference affiliation at any AME levels surveyed. A one-sample chi-square test was used to determine significance at each AME Church level. In order to denote significant relationships between variables, $p<.05$ on the chi-square test. The value for the Second Episcopal District was $p=.802$, for the District Conference $p=.534$ and for the local church, $p=.159$.

Of the 471 participants in the Midyear Conference survey, valid data indicated that: 170 (40.2%) reported that they had attended an HIV/AIDS presentation/workshop at a Second Episcopal District event; 152 (41.3%) at the District Conference level; and 229 (55.7%) at the local church level.

In terms of actual valid data (raw numbers), respondents were more likely to have participated in an HIV/AIDS presentation or workshop at the local church level than at the District Conference or Second Episcopal District Levels. This is not surprising since the frequency of meetings and opportunities for interaction by more than one organization (which might offer an HIV/AIDS awareness session) over an extended period of time is greater at the local level.

In addition, the extent to which constituents are faced with the impact of HIV/AIDS on infected and affected persons may have a greater influence on leadership decisions. For example, weekly prayer requests, home and hospital visits, requests for conduct of funerals, emergency assistance requests, diagnosis reports, and counseling needs are among the many service inquiries seen on an ongoing basis at the local church level. Since the District Conference and Second Episcopal District have important administrative responsibilities within the denominational structure, these types of day-to-day needs may not be as pressing to put on agendas. Nevertheless, when HIV/AIDS (or any other item) makes it to program, it indicates the importance, urgency and/or a leader(s) area of interest or organizational priority.

Ever Attended a HIV/AIDS Presentation or Workshop (in any setting and when)

There was a significant difference in participants who reported that they had ever attended an HIV/AIDS presentation and workshop (in any setting) by Annual Conference affiliation. A one-sample chi-square test was used to determine significance by Annual Conference. The results of the test were significant, (N=406) = 10.615, p = .031. The proportion of participants indicating that they had ever participated in a HIV/AIDS presentation or workshop did strongly correlate to the Annual Conference affiliation. Of the 471 participants in the Midyear Conference survey, valid data indicated that 406 (40.2%) reported that they had attended an HIV/AIDS presentation/workshop.

Of the 153 persons who responded to when they had participated in an HIV/AIDS presentation/workshop, 37 persons (7.9%) said they had attended in 2003 (the year survey was administered); 32 (6.8%) in the 1990s; 30 (6.4%) in 2002; 18 (3.8%) in 2001; 19 (4.0%) in 2000; and 13 (2.8%) said they attended a session annually.

Despite the limited number of persons responding to the location portion of Survey Question Five, there are still some implications for better understanding where church constituents obtain their HIV/AIDS presentations/workshops. The results show that when persons identify where they have participated in an HIV/AIDS workshop or presentation, about 21.0 % obtained information in a church context (including 12.5% in "Church" and 8.3% at "Any AME Level Other Than Local Church"). Next, persons identify the city and/or state of their session, even when nothing else is specified. It may be that the survey instrument should be revised to include specific answer choices to be checked to aid respondent recall and completion of the entire Survey Question Five.

School and job were tied for the next most prevalent location identified by respondents. When this is considered along with church context results, it implies that participation may be; voluntary, required; part of an established agenda or one's usual life events. It should be noted that six persons (1.3%) specified military as a context for their session. Other respondents may have included this under their job response.

Health agencies such as health departments, hospitals and clinics were listed as a source for HIV/AIDS presentations/workshops. It is interesting to note that few respondents stated physician's/doctor's office. This may be because the terms presentation and workshop imply group session, whereas most information distributed by physicians' offices are during one-on-one appointments or through materials (see Survey Question Six).

Shared or Heard A Clergyperson Discuss HIV/AIDS with the Church Congregation

Survey Question Nine was designed to assess the recent (past one-year) HIV/AIDS information that had been shared in congregations. Overall, the majority of respondents did not indicate that HIV/AIDS risks had been discussed in the past year with their congregations. Responses on the 471 surveys received were as follows: 180 persons (38.2%) said yes; 216 (45.9%) said no; and 47 (10.0%) said they don't know. Data was missing for 28 persons (5.9%).

Supplemental Quantitative Results

Additional quantitative data was collected to allow the ministry researcher to begin exploring the current access to educational materials and to better understand what

constituents know about the transmission of HIV. Of the 471 persons surveyed, 399 (84.7%) indicated they had reviewed HIV/AIDS pamphlets; 263 (55.8%) reviewed fact sheets; 329 (69.9%) reviewed brochures; and 149 (31.6%) reviewed videos.

The majority of constituents could correctly identify proven modes of transmission of HIV. However, there is still work to be done in educating persons, particularly to clarify *proven* modes of HIV transmission. This is evident by those persons who indicated kissing, 100 (21.2%) or who replied that the toilet, 28 (5.9%), were modes of transmission. This reflects a need for more specific HIV/AIDS awareness materials and training on modes of transmission for constituents.

Research Question Two

Research Question Two explored the likelihood that members would support an HIV/AIDS church-based awareness project among African Americans and in Southern Africa. There is sufficient evidence to suggest that constituents surveyed would be open to supporting further HIV/AIDS awareness projects, both domestic and international (in Southern Africa). The majority of respondents at the 2003 Midyear Meeting said that they were very likely to be supportive, 370 (78.6%) for African Americans and 253 (53.7%) for Southern Africa. When additional data is reviewed from persons "Somewhat" likely, those percentages of persons willing to support such projects rises to 442 (93.9%) for an African American project and for a Southern African project 397 (84.3%).

Research Question Three

Research Question Three included qualitative data to assess the readiness of various segments of the Second Episcopal District to address HIV/AIDS and related issues as perceived by selected leadership (i.e., Bishop, Episcopal Supervisor, Presiding Elders and Pastors). Selected results from the nine in-depth interviews were categorized by the challenges, opportunities, readiness and education (CORE). Diversity of responses was received in all categories. Overall, there is openness to conducting HIV/AIDS awareness activities, with a realistic understanding of the challenges facing such action. Further analysis of in-depth interviews is needed to enhance current and future mobilization areas.

Overview of Mobilization Efforts

Mobilization efforts in this project were inclusive of quantitative and qualitative research, as well as implementation of awareness activities. The following summarizes major mobilization accomplishments in this ministry project:

- An HIV/AIDS awareness survey was conducted and analyzed, with over 582 constituents responding in Maryland, District of Columbia, Virginia and North Carolina.
- Nine in-depth interviews were conducted with key leaders throughout the Second Episcopal District including Pastors, Presiding Elders, the Episcopal Supervisor and the Presiding Bishop.
- Multiple HIV/AIDS awareness materials were developed and disseminated including:

1. Over 4,792 Action Alerts for mass distribution
2. Approximately 700 of the 2004-2005 HIV/AIDS Awareness Action Packets containing denominational tools and strategies as well as statistics organized according to the Second District geographical regions
3. 500 DVDs entitled Second Episcopal District, African Methodist Episcopal Church HIV/AIDS Awareness: A Call to Action
4. HIV/AIDS Awareness displays customized for the five Annual Conferences of the Second Episcopal District containing a project overview, local and state data and HIV/AIDS awareness materials
5. Thirty-eight outreach activities and training events resulting in an estimated 5,155 contacts with constituents
6. Activities such as workshops, HIV testing/health screenings, special community outreach and worship services were conducted to support national HIV/AIDS awareness days
7. Ongoing dialogue with constituents to sustain interest and involvement in conducting HIV/AIDS (e.g., through technical assistance via telephone, fax, mail, meetings, workshops and other presentations with clergy and lay leaders as well as reports to the Board of Directors of Second District RED, Inc.)

Hypotheses

There were three hypotheses proposed in the project. The above quantitative and qualitative data supports the following:

1. Hypothesis One - *Supported* – There will be greater attendance at HIV/AIDS presentations and workshops at the local church level than at the District Conference and Second Episcopal District levels of the AME Church.
2. Hypothesis Two – *Partially Supported, More Analysis Needed* – There will be no significant differences between Annual Conferences in the likelihood that respondents will: 1) support an HIV/AIDS church-based project among African Americans, and 2) support an HIV/AIDS project focused on Southern Africa. Frequency and preliminary significance tests showed no difference between Annual Conferences in the willingness to support an African American and a Southern Africa project. Frequency data shows strong support for both projects. Further analysis is needed to establish significance findings.
3. Hypothesis Three- *Supported Quantitatively, More Qualitative Analysis Needed* – The Second Episcopal District will be perceived by church leaders as ready to address HIV/AIDS issues, given adequate training and other support services.

Reflections on Lessons Learned and Recommendations

The "Reflections" section of this chapter focuses on the implications of the doctoral project and the related recommendations in several areas: 1) Capacity-building; 2) Implementation of the SHINE Global Model - Phase I (Mobilization); 3) Areas for Further Research. The items reflected upon potentially impact not only to members of the Second Episcopal District of the AME Church (the context for this project), but also relates to other AME Episcopal Districts, as well as denominations of a similar structure. Religious institutions may find topics covered in this section that applies to their contexts.

Capacity-building

Understanding the constituent and institutional needs will help build the capacity of the Second Episcopal District and its affiliated non-profit organizations to better address HIV/AIDS. Results of the SHINE Model indicate that there have been some health and HIV/AIDS education activities occurring at various levels within the AME Church. Nevertheless, as the knowledge of how HIV is transmitted is considered, as well as the diversity in approaches needed to reach and sustain involvement of clergy and lay, it becomes more evident that more needs to be done.

First, the AME church, and indeed the Christian community at-large, must ask the question, how can HIV/AIDS awareness be increased through the traditional structures in the church? When we examine the Annual Conference and District Conference infrastructure, we must consider how these may be used as ongoing avenues for providing health and wholeness information to constituents.

Increasing awareness of HIV/AIDS on all levels of the Second Episcopal District (and most other Episcopal Districts) of the AME Church may have a profound impact on ministries to individuals, families and communities. Access to prevention information, particularly the modes of transmission of HIV/AIDS, will enhance the understanding of leaders such as Pastors and other clergy, lay persons, Presiding Elders, Episcopal Supervisors and Bishops. Individual one-on-one advisory and counseling sessions, outreach to underserved populations, sensitivity to prayer concerns and other spiritual needs are among the ministerial practice areas influenced by interventions like the SHINE Global Model.

Capacity-building Lessons Learned

- *The affiliation between PCOC, a community-based organization, and RED, a regional non-profit organization, created a good model for maximizing the reach and impact of a project to address a major health concern such as HIV/AIDS.* PCOC was able to extend its services beyond its headquarters in Washington DC and assist individuals and churches in Maryland, Virginia and North Carolina. RED received technical assistance to provide materials and training for its Second District constituents.
- *The collaboration with RED provided an appropriate and acceptable means for PCOC to obtain access to AME constituents and receive regular feedback on the project.* Collaboration also increased the sustainability of HIV/AIDS activities beyond the life of the project. RED has continued to provide educational resources and to collaborate with public and private agencies which address HIV/AIDS issues and provide services.
- *The initial public support of Second Episcopal District leaders was vital to the project's success. In particular, the Presiding Bishop and Episcopal Supervisor, as well as Presiding Elders and the Lay Organization President have significant influence in the hierarchical form of church governance.* Because these leaders oversee the work in multiple congregations, the ability to impact broadly increases the project's access to constituents, efficiency and acceptance.
- *Incorporating the HIV/AIDS messages into program plans of AME Church organizations and standing committees greatly facilitates mobilization.* For example, the Second Episcopal District Lay Organization linked the HIV/AIDS

awareness efforts with its Health and Wellness Directors in each of the five Annual Conferences.

- *Surveys and in-depth interviews were effective ways to assess the knowledge, attitudes and beliefs concerning HIV/AIDS among Second District constituents.* In addition, both tools were instrumental in sparking constituents to raise thought-provoking questions, engage in candid discussion, share the lessons learned from past and present HIV/AIDS efforts.
- *Churches and clergy and lay leaders in each Annual Conference were identified who have either already conducted HIV/AIDS awareness activities, have expressed interest in doing so, or have been recommended as possible participants in the project.*

Capacity-building Recommendations

1. *Utilize the skills of current and retired health professionals in local churches to provide ongoing education at the grassroots level.* The establishment of HIV/AIDS ministries, health and wellness committees provides avenues to directly raise HIV/AIDS awareness. In addition, other ways to increase awareness include incorporation of HIV/AIDS prevention messages into the materials and activities of youth, singles, couples, homeless and other inreach and outreach ministries.
2. *Continue follow-up with Social Justice and Community Action Committees of the Annual Conferences, especially where HIV/AIDS awareness was included in resolutions (e.g., North Carolina and Western North Carolina).*

3. *Incorporate HIV/AIDS awareness in the training of lay leaders and clergy.* Forums that can be used for this purpose include plenary sessions, presentations and workshops of lay organizations and ministerial education seminars. Meetings of these components may provide a suitable context: Women's Missionary Society, Young People's Division, the Lay Organization, Church School, and the Christian Education Department. In addition, the AME Institutes or Board of Examiners' curriculum for students entering the ministry, continuing education courses and seminars, and clergy retreats may provide other training opportunities.
4. *Use PCOC and Second Episcopal District/RED websites as a means of sharing information with constituents.* This should include links to other websites with HIV/AIDS information.
5. *Obtain the endorsement (written and verbal preferred) of clergy and lay leadership at various levels. This will assist in authenticating the work being done to promote HIV/AIDS awareness.* Where key denominational leadership gives commendation of the prevention and care efforts, the occasion and date should be referenced in subsequent project activities.

   This is especially true where strong support is exhibited among the Episcopal Leaders (i.e., Presiding Bishop and Episcopal Supervisor) and other jurisdictional leaders (e.g., Presiding Elders, Conference Branch Presidents) as well as Episcopal District officers (e.g., Episcopal District Lay Organization, Women's Missionary Society etc.).
6. *Complete a SHINE Global Model HIV/AIDS awareness report to RED and the Second Episcopal District, containing overall project lessons learned and*

recommendations, final HIV/AIDS survey results, and outcomes of in-depth interviews with Presiding Elders and Pastors in each of the five Annual Conferences.

7. *Train-the-trainer workshops and strategy sessions should be conducted and related resource guides compiled for each Annual Conference, to support ongoing work of church organizations (e.g., Lay Organization, Health Commissions, Women's Missionary Society and Young People's Division etc.).*
8. *Continue to collect and utilize AME and other publications as references.* Examples can be obtained from work in other AME Episcopal Districts (in the United States and abroad) and other denominations.
9. *Create a Second District HIV/AIDS resource guide, with information grouped by jurisdiction.* Government and community contacts, speakers' bureau information and volunteers for providing technical assistance should be listed.
10. *Increase the number of educational opportunities for raising awareness on HIV/AIDS and other health initiatives during Episcopal District and District Conference events*. Examples of areas where HIV/AIDS could be included are: standing committee reports, display booths in exhibit areas, guest presenters and greetings from health professionals and advocates who are located in the vicinity of denominational meetings.

Implementation of the SHINE Global Model - Phase I (Mobilization)

Methods were employed to incorporate mobilization efforts mentioned above into the SHINE Global Model. The process for implementing Phase I was dynamic, and at times,

required both staff and considerable volunteer support of persons in the ministry context. Having the accessibility of grant funds greatly aided the production of mobilization materials and ongoing operation of the project.

Implementation Lessons Learned

- As indicated in the above capacity-building section, *support of Episcopal District leadership (both clergy and lay) prior to officially launching the project to the broader body, and throughout implementation, helped ensure acceptance and that appropriate methods were employed.*
- *Resource materials such as HIV/AIDS Action Alerts, the 2004-2005 HIV/AIDS Awareness Action Packets and the HIV/AIDS Awareness: A Call to Action DVDs were all well received.* The staggered release of these items helped build momentum for the project, and kept constituents aware of topics.
- *In each of the five Annual Conferences, persons made requests for additional information to be used for their local prevention efforts.*
- *Constituents expressed their interest through responses to invitations received during the season of the 2004 Annual Conferences to do further work with persons engaged in outreach to youth and young adults, prison ministries and other outreach activities.*
- *Additional DVD footage containing taping of youth, Second Episcopal District officers and other church leaders is available for future DVDs and for historical reference.*

Implementation Recommendations

1. *Continue to conduct and support of workshops, presentations and materials such as the Action Alerts and Action Packets for dissemination throughout the Second District.*
2. *Increase the number of educational opportunities for raising awareness on HIV/AIDS and other health initiatives during Episcopal District and District Conference events.* Examples of areas where HIV/AIDS could be included are: standing committee reports, display booths in exhibit areas, guest presenters and greetings from health professional and advocates who are located in the vicinity of denominational meetings.
3. *Give special care to implementing and ensuring appropriate outreach strategies to obtain youth and young adult participation.*
4. *Continue to follow-up and do further work to promote HIV/AIDS prevention and care, with persons who serve youth, young adults, prisoners, previously incarcerated persons and others reached through existing outreach activities of churches and other faith-based organizations.*
5. *Additional copies of the first DVD, "HIV/AIDS Awareness: A Call to Action," should be made available for use in conjunction with ongoing leader training.*
6. *Continue editing and complete additional taping, as necessary, for a second HIV/AIDS awareness DVD. This DVD should include various perspectives of clergy, adult lay persons, youth and local churches.* Final production should be scheduled for ideal release during the series of Annual Conferences.

7. *Explore possibilities of collaborating with AME educational institutions in promoting HIV/AIDS and other health initiatives.* Examples of AME institutions of higher education in the United States include: Allen University (Columbia, South Carolina); Edward Waters College (Jacksonville, Florida); Morris Brown College (Atlanta, Georgia); Paul Quinn College (Dallas, Texas); Payne Theological Seminary (Wilberforce, Ohio), Turner Theological Seminary at the Interdenominational Theological Center (Atlanta, Georgia); and Wilberforce University (Wilberforce, Ohio).

In addition, there are pre-school, primary and secondary schools throughout the AME Connection (globally) which could provide other opportunities for promoting healthy lifestyles to children, youth and adults, as well as to their parents and guardians. Some of the educational institutions that could also benefit from implementation of the SHINE Global Model include: AME University (Liberia, West Africa); Monrovia College (Monrovia, Liberia, West Africa); R.R. Wright Theological Seminary (Republic of South Africa); Sizanne School (Bulawayo, Zimbabwe); and Wilberforce Community College (Evaton, South Africa).

Areas for Further Research

Both qualitative and quantitative data collected in this ministry research project point to the need for further study and analysis. Some lessons learned for further research are provided followed by recommendations.

Research Lessons Learned

- *Quantitative and qualitative research demonstrated that there is an overall receptivity to HIV/AIDS projects among Second Episcopal District members.* For example, people were receptive to the survey which was distributed after an introductory announcement by a leader. Endorsements of the project by the Bishop and Episcopal Supervisor spanning two administrations were essential to the success of the project. This aided the short- and long-term mobilization efforts.
- *A pilot test of the survey was conducted prior to the administration of the survey to a broader sample, the Second Episcopal District.* Still, some criteria were omitted from the final survey due to space limitations (i.e., desire to keep survey only one page) and desire to indicate to participants that only limited personal information was requested. This was the first known time that such a survey was conducted in the Second District. Special care was taken to make sure surveys were folded before being turned in, and that the staff collecting surveys did not look at surveys once deposited into the retrieval containers.
- *Age and clergy/lay status were the most sensitive items on the instrument.* Asking persons to list a specific age as opposed to checking an age range may not have been the best option (except for space considerations). For some, age is already a sensitive issue, and for a survey, there may have been concern that they would be identified, especially with the Annual Conference, Gender, and Clergy/Lay status. Furthermore, since the Presiding Bishop (who was also the Chairman of RED) was encouraging participation, despite assurances of confidentially, some persons

may have doubted or hesitated to give information that could be traced back to them.

- *Unfortunately, marital status and, for certain questions, Annual Conference affiliation was mistakenly left off the survey.* Marital Status was an important indicator for HIV/AIDS research and basic demographics. Again, space limitations would still have made it difficult to include and maintain clarity and good spacing on the instrument. Marital status should be included in future studies. In addition, for questions three and four, Annual Conference level was omitted for the items on history of participation in a health and HIV/AIDS presentation or workshop. Originally, space considerations, and the fact that RED or the Bishop's office had not conducted a presentation was a rationale for exclusion. However, in the 2004 Series of Annual Conferences, RED in conjunction with PCOC had disseminated materials, and in some cases made presentations. Inclusion of the Annual Conference question would have been helpful for comparison. Furthermore, it was discovered that some Annual Conferences had had health and HIV/AIDS presentations in prior years.
- *It became evident that a small number of persons may not have been as familiar with the term clergy, so it is better to indicate ordained minister.* Ordination is an indicator for the AME Church that implies clergy, since it is viewed by some in leadership that lay persons can also be engaged in ministry, and thus we hear terms such as "Minister of Music." It is assumed that most ordained ministers would have known the difference between clergy and lay. Nevertheless, when data was reviewed in samples *other* than the 2003 Midyear Meeting, confusion

was evident. Based on the number of known clergy in the setting at the time of administration, there was discrepancy in the number of respondents selecting clergy.

- *Because the HIV/AIDS survey was completed primarily among those who attended the 2003 Midyear Meeting, results are perhaps more representative of clergy and lay leaders who regularly attend Episcopal District meetings or who are active at various levels beyond the local church.*

  Persons who did not generally participate in meetings beyond the local church level may not have been able to answer questions pertaining to health and HIV/AIDS presentation and workshop attendance, awareness levels at the District Conference, Annual Conference Second Episcopal District levels.

- *Additional analysis of qualitative data (e.g., in-depth interviews) is needed in light of the diversity of opinions received from persons serving at different levels of the AME Church.* Follow-up questions that relate to specific research questions may prove helpful. Overall, further analysis will facilitate enhanced, appropriate outreach strategies.

Further Research Recommendations

1. *Revise current survey instrument and explore the feasibility of collecting additional demographic information on marital status, educational background and income level, and including more specific answer choices and less open ended questions (e.g., timeframe and location of HIV/AIDS trainings).*

2. *Use the 2003-2004 results as a baseline, and repeat survey and in-depth interviews in several years to compare and contrast results after continuous HIV/AIDS interventions.* Sampling for the survey should include persons who do not usually attend Second Episcopal District meetings (i.e., persons whose involvement is primarily at the local church level).

3. *Conduct surveys and in-depth interviews with laypersons, youth and young adult leadership in the AME Church.* This is essential since laypersons represent the majority of the members of the denomination and play an active role in the spreading health promotion messages within the congregation and throughout the neighboring communities. Youth and young adult feedback is needed, as well as input from persons over 50, so that appropriate messages, materials and training sessions can be developed. New modes of administering the survey through an organizational website or other electronic means may be helpful in achieving this.

4. *Conduct surveys and in-depth interviews with governmental and private organizations and businesses, regarding enhancing collaboration to facilitate church-initiated and sponsored interventions.*

5. *Further explore lessons learned and operational strategies of churches that engage in HIV/AIDS prevention and care activities in the Second District.* This information will support the completion of constituent reports and resource guides, and will also be useful in training sessions. In particular, AME churches and their affiliated organizations should be contacted to see if they have HIV/AIDS ministries, have received public or private funding for prevention and treatment services, or if support is given to orphans or global health efforts. One

example of a treatment funding for agencies supporting lower-income residents without health insurance is the Ryan White Title I, II and III Programs of the United States Department of Health and Human Services, Health Resources and Services Administration.

6. *Further analyze the survey results from the Southern District of the North Carolina Annual Conference and Lee Memorial AME Church.* These results should continue to be compared to the Midyear Meetings results, and insights obtained from in-depth interviews by Presiding Elders and Pastors.

Conclusion

There is tremendous fulfillment in spreading the love of Jesus Christ to all people, regardless of racial or ethnic background, age, socioeconomic status, religion or even behavioral factors such as sexual activity or intravenous drug use. The challenge of the twenty-first century church and beyond is to address the pain and promise of the masses of people in a meaningful and pragmatic way. HIV/AIDS and its associated maladies pose an opportunity for congregations worldwide to respond pro-actively to the diverse needs of those within the church and in the surrounding communities.

Testimonies of those living with HIV and AIDS shout for a response: a young woman who is also an intravenous drug user impatiently awaits her white cell count to assess how well her immune system is functioning; a middle-aged widow cries as she reflects on the deaths of her husband and others, and wonders how long she has before the disease takes her too; a recently diagnosed professional who has not had sexual intercourse in years is challenged by her new reality following a precautionary checkup

after learning an ex-boyfriend's HIV status; a teen fears dating a young man who may be "on the down low," portraying himself as a heterosexual while engaging in homosexual activity; and a man dying with AIDS struggles with faith and forgiveness before he takes his last breath. The faces and stories of those infected and affected by HIV/AIDS compel action by society, and the faith community in particular. Their concerns should not, and indeed, cannot be neglected. Their echoes are heard in prayer requests, hospital and hospice visits, funerals, and the realities of behavioral risks of the young and old.

Careful consideration has been given in this project to better understand, as pertaining to HIV/AIDS awareness and care efforts, the knowledge, attitudes and roles of clergy and lay leaders who are members of the Second Episcopal District, African Methodist Episcopal Church. This project of a mid-Atlantic United States constituency provides insights on the readiness of this segment of the denomination to address HIV/AIDS. More follow-up activities are needed and planned. Furthermore, the Mobilization Phase of the SHINE Global Model provides a suitable framework to achieve the aim of addressing health and wholeness concerns in the AME Church and other similar bodies.

The joy and challenges experienced while conducting this action research project has had a profound impact on this ministry researcher's life, ministry and future direction. The commitment to promoting health and wholeness in persons worldwide is stronger than ever. The fields of ministry, medicine and public health converge at the cross of Jesus Christ, where there is forgiveness, healing, love and reconciliation to God. It is the ministry researcher's sincere hope that from mobilization to replication, the SHINE Global Model will prove useful in helping share God's unconditional love and compassion for all persons infected and affected by the HIV/AIDS pandemic.

GLOSSARY

Note: Terms listed below comprise the working definitions the ministry researcher used while conducting the project.

affected. Individuals or communities impacted by HIV and AIDS, emotionally, environmentally, financially, physically, and/or socially. Examples of those associated with person(s) diagnosed with HIV and AIDS include: family, friends, businesses, and sacred and secular institutions.

infected. Persons who have been diagnosed with HIV and/or AIDS.

inreach. Refers to efforts conducted within the church or faith-based organization's structure or that are designed to meet the needs of church members or others who regularly attend or worship in a faith or religious context.

outreach. Refers to efforts to recruit or inform members of the community at-large, beyond local churches or specific religious contexts.

prevention. Interventions that provide education, information and resources that help persons learn about risk factors and behavioral changes needed to avoid HIV infection.

care. Interventions that involve treatment, rehabilitation or support services (e.g., food, counseling, transportation) that assist persons infected or affected by HIV and AIDS.

faith-based. Programs, policies or initiatives that are designed, managed, or evaluated from a spiritual perspective or by a designated body holding an identifiable belief and value system. There may or may not be an allegiance with a practices consistent with a particular religion or denomination, while often this is the case.

APPENDIX A

DEMOGRAPHICS

DEMOGRAPHICS

TABLE A.1. TOTAL POPULATION TRENDS IN THE REGION OF THE SECOND EPISCOPAL DISTRICT

Data Source: United States Census Bureau, 2006 Population Estimates, Census 2000, 1990 Census http://factfinder.census.gov/servlet)
Note: The change in the order data (to chronological order) and the inclusion of the total column were completed for the purpose of this project.

STATE/DISTRICT	1990	2000	2006
Maryland	4,781,468	5,296,486	5,615,727
District of Columbia	606,900	572,059	581,530
Virginia	6,187,358	7,078,515	7,642,884
North Carolina	6,628,637	8,049,313	8,856,505
TOTAL	**18,204,363**	**20,996,373**	**22,696,646**

TABLE A.2. AFRICAN AMERICAN POPULATION IN THE REGION OF THE SECOND EPISCOPAL DISTRICT

Data Source: – Census 2000 Demographic Profile Highlights: Selected Population Group: Black or African American Alone, United States Census Bureau, Summary File 2 (SF2) and Summary File 4 (SF4)

Note: The percentage of Black or African Americans in the State/District of Columbia and the total column was calculated for the purposes of this project.

Location	Total State/District of Columbia Population (2000 Census)	Number of Black or African Americans Alone in Total State/District of Columbia Population (% of State/District of Columbia Total Population)	Number of Black or African American Families below the poverty line (Comparison Number in Total Population) *Percent African American*	Number of Black or African American Individuals below the poverty line (Comparison Number in Total Population) *Percent African American*
Maryland	5,296,486	1,477,411 (27.9%)	44,014 (83,232) ***52.9%***	210,999 (438,676) ***48.1%***
District of Columbia	572,059	343,312 (60.0%)	16,753 (19,365) ***86.5%***	84,098 (109,500) ***76.8%***
Virginia	7,078,515	1,390,293 (19.6%)	56,342 (129,890) ***43.4%***	250,903 (656,641) ***38.2%***
North Carolina	8,049,313	1,737,545 (21.6%)	86,428 (196,423) ***44.0%***	379,349 (958,667) ***39.6%***
Totals	20,996,373	4,948,561 (23.6%)	203,537 (428,910) ***47.5%***	925,349 (2,163,484) ***42.8%***

TABLE A.3. SOCIAL CHARACTERISTICS IN THE REGION OF THE SECOND EPISCOPAL DISTRICT

Data Source: – Census 2000 Demographic Profile Highlights: Selected Population Group: Black or African American Alone, United States Census Bureau, Summary File 2 (SF2) and Summary File 4 (SF4)

Note: The general or overall population data for the State/District of Columbia is provided in parentheses. The percentage of Black or African Americans in the State/District of Columbia and the total column were calculated for the purposes of this project.

Location	Population 25 Years and over	High School Graduate or higher	Bachelor's degree or higher	*Male, now married, except separated	*Female, now Married, except separated
Maryland	894,968 (3,495,595) ***25.6%***	706,552 (2,930,509) ***24.1%***	181,624 (1,099,360) ***16.5%***	221,071 (1,110,118) ***19.9%***	200,261 (1,087,740) ***18.4%***
District of Columbia	223,292 (384,535) ***58.1%***	157,124 (299,286) ***52.5%***	39,070 (150,237) ***26.0%***	35,038 (72,038) ***48.6%***	33,456 (69,954) ***47.8%***
Virginia	833,512 (4,666,574) ***17.9%***	596,593 (3,801,964) ***15.7%***	125,998 (1,374,988) ***9.2%***	227,304 (1,584,272) ***14.3%***	199,434 (1,547,987) ***12.9%***
North Carolina	1,025,276 (5,282,994) ***19.4%***	725,132 (4,128,270) ***17.6%***	134,775 (1,186,713) ***11.4%***	266,273 (1,815,945) ***14.7%***	246,285 (1,780,893) ***13.8%***
Totals	2,977,048 (13,829,698) ***21.5%***	2,185,401 (11,160,029) ***19.6%***	481,467 (3,811,298) ***12.6%***	749,686 (4,582,373) ***16.4%***	679,436 (4,486,574) ***15.1%***

*Population 15 Years and over

TABLE A.4. ANNUAL CONFERENCE MEMBERSHIP, SECOND EPISCOPAL DISTRICT

Data Source: Summary data was obtained from reports or documents distributed to constituents by the Presiding Bishop. For example, the data for 2006-2007 was presented in the Planning Meeting 2007 Workbook and Agenda which was disseminated in June 2007 following the completion of all five Annual Conferences. Composite data originate from Pastoral Reports at Annual Conferences.

Note: Yearly data is reported at the convening of each Annual Conference, typically in spring season.

ANNUAL CONFERENCE	2005-2006	2006-2007
Baltimore	29,941	30,526
Washington	49,422	51,540
Virginia	9,976	9,459
North Carolina	9,430	9,141
Western North Carolina	14,023	14,023
TOTAL	**112,792**	**114,689**

TABLE A.5. NUMBER OF CHURCHES, SECOND EPISCOPAL DISTRICT

Data Source: Summary data was obtained from reports or documents distributed to constituents by the Presiding Bishop. For example, the data for 2006-2007 was presented in the Planning Meeting 2007 Workbook and Agenda which was disseminated in June 2007 following the completion of all five Annual Conferences.

ANNUAL CONFERENCE	PRESIDING ELDER DISTRICTS (Number of Churches in the District)			TOTAL NUMBER OF CHURCHES BY ANNUAL CONFERENCE
Baltimore	Baltimore (30)	Eastern (30)	N/A	60
Washington	Capitol (40)	Potomac (40)	N/A	80
Virginia	Portsmouth/Richmond/ Roanoke (28)	Norfolk/Eastern Shore (33)	N/A	61
North Carolina	Northern (45)	Southern (41)	N/A	86
Western North Carolina	Western (30)	Central (25)	Eastern (26)	81
TOTAL NUMBER OF CHURCHES (ALL ANNUAL CONFERENCES)				**368**

APPENDIX B

HIV/AIDS STATISTICS AT PROJECT INITIATION

HIV/AIDS MORBIDITY AND MORTALITY

Table B.1. Selected HIV Infection Cases at the Start of Project

Source: Henry J. Kaiser Family Foundation, Reported through December 2002
** Maryland and District of Columbia data were not available due to code-based reporting of HIV Data in these jurisdictions.*

LOCATION	CUMULATIVE NUMBER OF HIV INFECTION CASES	CUMULATIVE ADULT/ADOLESCENT HIV INFECTION CASES	ANNUAL REPORTED HIV INFECTIONS
United States	199,759	195,401	35,147
Virginia	9,277	9,198	999
North Carolina	11,560	11,432	1,118

Table B.2. Cumulative and New AIDS Cases at the Start of Project
Source: Henry J. Kaiser Family Foundation, Reported through December 2002
** Second Episcopal District totals were computed for the purposes of this project.*

LOCATION	CUMULATIVE AIDS CASES	NEW AIDS CASES AMONG AFRICAN AMERICANS
United States	859,000	21,787
Maryland	14,882	801
District of Columbia	25,358	1,563
Virginia	12,384	756
North Carolina	14,959	999
**Second Episcopal District* (Sum of MD, DC,VA and NC)	67,583	4,119

Table B.3. Nine-Year AIDS Survival Rates in the United States

Sources:
Centers for Disease Control and Prevention, *CDC HIV/AIDS Fact Sheet: HIV/AIDS among African Americans.* (Atlanta, GA: CDC, December 2002), 1.

Centers for Disease Control and Prevention, *CDC HIV/AIDS Fact Sheet: HIV/AIDS among African Americans.* (Atlanta, GA: CDC, January 2007), 2.

RACIAL/ETHNIC GROUP	1994-2002	1997-2004
African Americans	55%	66%
American Indians and Alaskan Natives	Data Not Available	67%
Hispanics	61%	74%
Whites	64%	75%
Asian/Pacific Islanders	69%	81%

APPENDIX C

HURDLER THEOLOGY

Figure C.1. Summary of Main Hurdler Theology Components

Preparation For The Race – The preparation consists of those elements that serve to equip and shape an individual, family or community for all that life may bring. History, God relationship, eternal purpose or God-given talent, and health and wholeness are integral components in the preparation phase. Other factors influencing readiness for a hurdle race include: practice and commitment; dress and grooming, pre-race thinking; pre-race talking; lane assignment; and vision.

Race – The point in which a hurdler makes a commitment to Christian living. The race portion of hurdler theology is primarily the life experiences of the individual, family or community (units of analysis). Someone has entered the race when he/she decides to make following the teachings and practices of Jesus Christ as a key life priority. This includes assisting others in their race by offering comfort and tools for living healthy and whole. The race consists of the following: strategic points (e.g. the start, the curves and the final leg); energy level (e.g. reserves, pace and attacking the hurdles); and distractions (e.g. certain thoughts, other people, unrelated goals, sounds, objects and the body state or weaknesses).

Finish – The finish line has current life and eschatological implications, and refers to a particular end or goal sought in life. It consists of the reasons for living. There are transitional finishes that occur throughout life. Also, there is an ultimate, latter day finish line that is salvation through Jesus Christ. The key component of the finish line is evaluation. Key evaluation indicators are: personal, family and/or community reaction; head coach feedback (written or inspired); and debriefings.

Ministerial Reflections – Both clergy and laypersons may experience ministerial reflections. These reflections allow persons to ponder lessons learned, race challenges, and future direction. Each transitional finish enables contains new opportunities to review and begin a new race until the ultimate finish line is crossed at the end of life, Second Coming or Judgment Day.

Figure C.2. Explanation of Key Hurdler Theology Terms

Hurdler/Runner – The male or female who prepares for the race of life.

Hurdles – The challenges and struggles faced in life.

Owner – God is the creator, *owner* and sustainer of the team of hurdlers. The Trinity or Godhead works together in love for the good of the individual hurdlers and team. The owner is the ultimate authority over all team transactions including the provision of resources to support the team eternally.

Head Coach – Jesus serves as the head coach. The head coach is the one who provides an example for hurdlers, and encourages their faithful engagement in the race to facilitate spiritual growth and development. However, in some instances the head coach may instruct the hurdler *not* to run in a particular race. Examples of rationales for not participating in the race may be in cases of injury, heartbreak, unforeseen dangers and needs for further skill development or emotional or spiritual maturity.

Assistant Coaches – Clergy or lay leaders in the church may serve as assistant coaches. In some cases family members or close friends may serve in this role, as long as the primary purpose is to give assistance in spiritual growth and development.

Team – The church or *ekklesia* refers to that group joined together to learn, worship and celebrate its faith in God. A team may refer to ministerial settings such as a local church, para-church ministry, or Christian support group.

Crowd – Those persons who are observing the race or one's life, but are either not known or lacking a close relationship with the hurdler(s). These persons serve no particular role in the hurdler's life; however, their responses or reactions on the sidelines may distract or discourage the hurdler or the team.

Fans/Personal Cheerleaders – Those confidants who always seem to "have one's back" such as prayer partners, close friends and acquaintances. A hurdler will typically find comfort in knowing that the fans or cheerleaders are nearby or thinking or praying for them at the various stages of the preparation, race or finish.

Energy – The Holy Spirit provides energy, insight and inspiration to the Christian believer. Consciously and subconsciously the Holy Spirit is at work with hurdler, encouraging him/her to continue in the race of Christian Living.

APPENDIX D

PROJECT DATA COLLECTION INSTRUMENTS

NOTE:

All questions and entries on the data collection instruments that follow are the same as those used in the project. However, the format of the instruments may have been revised. For example, the original Midyear Conference HIV/AIDS Survey had a length of one page. In-depth interviews may have been longer for ease in recording data during recorded sessions.

SECOND DISTRICT RELIGIOUS, EDUCATIONAL AND CHARITABLE

DEVELOPMENT PROJECTS, INC.

(2ND DISTRICT RED, INC.)
A SUBCONTRACTOR OF THE PILGRIM COMMUNITY OUTREACH CORPORATION, INC. (PCOC)

HIV/AIDS SURVEY (v. 11-01-03)

This survey is being conducted to determine the educational needs of lay and clergy within faith-based institutions regarding HIV/AIDS. Please do not place your name or other identification marks on the survey. Please answer each item as indicated.

1. What is your Annual Conference and position within the Church?
(Check all that apply.)

a. Baltimore____ Washington____ Virginia____ North Carolina___ Western North Carolina___

b. Clergy_____ Lay_____

2. What is your current: Age ____ Gender Male___ Female____
Ethnic/Racial Group _____

3. Have you ever attended a health presentation or workshop at a:

a. Second Episcopal District Event (e.g. Founder's Day)? Yes_____No_____

b. Local Church? Yes_____ No_____

c. District Conference? Yes_____ No_____

4. Have you ever attended an HIV/AIDS presentation or workshop at a:

a. Second Episcopal District Event (e.g. Founder's Day)? Yes_____No_____

b. Local Church? Yes_____ No_____

c. District Conference? Yes_____ No_____

5. Have you ever attended an HIV/AIDS presentation or workshop, if yes when and where?

No___ Yes___ **If Yes, When?**_____ **Where?**_____

6. Have you ever reviewed any literature on HIV/AIDS? *(Check all that apply.)*

Pamphlets_____ Fact Sheets_____ Brochures_____ Videos _____

7. How likely is it that you would support an HIV/AIDS church-based awareness project focused on African Americans?

Very Likely_____ Somewhat Likely_____ Unlikely____
Not at all ____ Unsure _____

8. How likely is it that you would support an HIV/AIDS awareness project focused on Southern Africa?

Very Likely_____ Somewhat Likely_____ Unlikely____
Not at all _____ Unsure _____

9. Within the past year have you or any other member of the clergy discussed the risks of HIV/AIDS with the church congregation? Yes_____ No _____
Don't Know _____

10. HIV/AIDS can be transmitted by: *(Check all that apply.)*

Kissing_____ Sexual Contact _____ IV Needle Sharing____
Blood Transfusions_____ Toilet_____

Please fold this survey and hand it to a designated representative. Thank you for your participation.

BISHOP
IN-DEPTH INTERVIEW
(V.1)

Date Interview Completed_____ Start Time _____End Time_____

Interviewer _____ Tape #_____ Counter Start_____

Counter End _____

Interview # _____

Conduct Method: In-person_____Phone_____ Other (Please specify)_____

Greetings. Thank you for agreeing to do this interview that was designed to assist in understanding the needs to increase HIV/AIDS prevention and care activities in your Episcopal District. The questions are similar to those asked in earlier interviews with Presiding Elders and Pastors in each Annual Conference. **Do you mind if this interview is taped? This question will be repeated after the recorder is turned on.**

The responses will be used to assist with understanding data on an Annual Conference Level. Please note that this data is being collected as a part of a Doctor of Ministry project with United Theological Seminary as well as HIV/AIDS project activities of Pilgrim Community Outreach Corporation. **Do you have any objection to this interview transcript being used for these purposes?**

For more information please contact Rev. Cassandra Sparrow at (XXX) XXX-XXXX or (XXX) XXX-XXXX.

1. **Do you recall the HIV/AIDS Survey disseminated at the 2003 Midyear conference in Raleigh, NC?**

How useful do think the survey instruments and the results will be to the work on your Episcopal District?

Have you conducted similar surveys on your Episcopal Districts in the past? Please explain.

2. **On a scale of 1-5 where 1 is low and 5 is high, how would you rate the overall readiness of churches on your Episcopal District to address HIV/AIDS?**

Please explain your response.

3. **Are you aware of any other churches or agencies in your Episcopal District engaged in efforts to address HIV/AIDS?**

4. **Has there ever been a Health Presentation under your leadership at: 1) an Episcopal District Meeting and 2) an Annual Conference? How long ago?**

1) Episcopal District

2) Annual Conference

Do you recall, what areas were addressed? HIV/AIDS?

5. **What do you think the major <u>opportunities</u> are to implementing HIV/AIDS awareness project in your Episcopal District?**

6. **What do you think the major challenges are to HIV/AIDS awareness project in your Episcopal District?**

7. **How open are you in your position as Bishop to help raise awareness on HIV/AIDS?**

If open, what could assist you?

Either way, are there any concerns or conditions that might hinder your involvement?

This concludes the primary questions for this interview. Please assist further by providing additional background information.

BACKGROUND INFORMATION

ITEM	RESPONSE	COMMENTS
Length of Time as Bishop in any Episcopal District		
Length of Time in Pastorate (Any Location)		
Length of Time in Ordained Ministry (1st Ordination)		
Episcopal Districts Served in to date (As clergy & lay)		
Annual Conferences Served in to date		
How would you classify the location of most of the churches on your District? (Urban, Suburban, Rural)		
Size of District (# of churches)		
Highest Educational Level Achieved		
Gender		
Race		

Thank you for your contribution to this project.

EPISCOPAL SUPERVISOR'S
IN-DEPTH INTERVIEW SUMMARY
(V.1)

Greetings. Thank you for agreeing to do this interview that was designed to assist in understanding the needs to increase HIV/AIDS prevention and care activities in the Second Episcopal District. The questions are similar to those asked in earlier interviews with Presiding Elders and Pastors in each Annual Conference. **Do you mind if this interview is taped? This question will be repeated after the recorder is turned on.**

The responses will be used to assist with understanding data on an Annual Conference Level. Please note that this data is being collected as a part of a Doctor of Ministry project with United Theological Seminary as well as HIV/AIDS project activities of Pilgrim Community Outreach Corporation. **Do you have any objection to this interview transcript being used for these purposes?**

For more information please contact Rev. Cassandra Sparrow at (XXX) XXX-XXXX or (XXX) XXX-XXXX.

1. **Do you recall the HIV/AIDS Survey disseminated at the 2003 Midyear conference in Raleigh, NC? How useful do you think the survey instruments and the results will be to your work on the Episcopal District? Have you conducted similar surveys on your Episcopal Districts in the past? Please explain.**

Preliminary assessment shows that approximately 582 surveys were received from members of the 2nd Episcopal District* including: *12 during the pilot test, 471 surveys during the Mid-Year Conference, 99 at a District Conference and a Local Church.

2. **On a scale of 1-5 where 1 is low and 5 is high, how would you rate the overall readiness of the Women's Missionary Society in your Episcopal District to address HIV/AIDS? Please explain your response.**

3. **Are you aware of any churches or agencies in your Episcopal District engaged in efforts to address HIV/AIDS? Your response may also include information at any level of the Women's Missionary Society.**

4. **Has there ever been a Health Presentation under your leadership at a: 1) Episcopal District meeting, 2) Annual Conference or 3) Women's Missionary Society events**

   How long ago? Do you recall, what areas were addressed? HIV/AIDS?

5. **What do you think the major opportunities are to implementing a HIV/AIDS awareness project in your Episcopal District?**

8. **What do you think the major challenges are to implementing a HIV/AIDS awareness project in your in your Episcopal District?**

9. **How open are you in your position as Episcopal Supervisor to help raise awareness on HIV/AIDS? If open, what could assist you? Either way, are there any concerns or conditions that might hinder your involvement?**

This concludes the primary questions for this interview. Please assist further by providing additional background information.

BACKGROUND INFORMATION

ITEM	RESPONSE
Length of Time as Episcopal Supervisor in any Episcopal District	
Length of Time in Women's Missionary Society at any level	
Length of Time in Health Field	
Episcopal Districts Served in to date	
Annual Conferences Served in to date	
How would you classify most of the WMS outreach activities on your Districts to date? (Urban, Suburban, Rural)	
Size of District (# of local WMS)	
Highest Educational Level Achieved	
Gender	
Race	

Thank you for your contribution to this project.

BALTIMORE
PRESIDING ELDER LEADERSHIP
IN-DEPTH INTERVIEW
(V.2)

Date Interview Completed_____ Start Time _____End Time_____

Interviewer _____ Tape #_____ Counter Start_____

Counter End _____

Interview # _____

Conduct Method: In-person_____Phone_____ Other (Please specify)_____

Greetings. Thank you for agreeing to do this interview that was designed to assist in understanding the needs to increase HIV/AIDS prevention and care activities in your District Conference. **Do you mind if this interview is taped? This question will be repeated after the recorder is turned on.**

The responses will be used to assist with understanding data on an Annual Conference Level. Please note that this data is being collected as a part of a Doctor of Ministry project with United Theological Seminary as well as HIV/AIDS project activities of Pilgrim Community Outreach Corporation. **Do you have any objection to this interview transcript being used for these purposes?**

For more information please contact Rev. Cassandra Sparrow at (XXX) XXX-XXXX.

1. **Do you recall the HIV/AIDS Survey disseminated at the 2003 Midyear conference in Raleigh, NC?**

   Did you complete the survey?

Preliminary assessment shows that approximately 63 surveys were received from members of the Baltimore Annual Conference.

2. **On a scale of 1-5 where 1 is low and 5 is high, how would you rate the overall readiness of churches on your District to address HIV/AIDS?**

   Please explain your response.

3. **Are you aware of any other churches or agencies in your District engaged in efforts to address HIV/AIDS?**

4. **Has there ever been a Health Presentation at a District Conference under your leadership?**

   How long ago? Do you recall, what areas were addressed? HIV/AIDS?

5. **What do you think the major <u>opportunities</u> are to implementing HIV/AIDS awareness project in your District Conference?**

10. **What do you think the major challenges are to HIV/AIDS awareness project in your District Conference?**

11. **How open are you in your position as Presiding Elder to help raise awareness on HIV/AIDS?**

If open, what could assist you?

Either way, are there any concerns or conditions that might hinder your involvement?

This concludes the primary questions for this interview. Please assist further by providing additional background information.

BACKGROUND INFORMATION

ITEM	RESPONSE	COMMENTS
Length of Time as Presiding Elder at Current Charge		
Length of Time in Pastorate (Any Location)		
Length of Time in Ordained Ministry (1st Ordination)		
Episcopal Districts Served in to date (As clergy & lay)		
Annual Conferences Served in to date (Including current)		
How would you classify the location of most of the churches on your District? (Urban, Suburban, Rural)		
Size of District (# of churches)		
Highest Educational Level Achieved		
Gender		
Race		

Thank you for your contribution to this project.

VIRGINIA
PRESIDING ELDER LEADERSHIP
IN-DEPTH INTERVIEW
(V.1)

Greetings. Thank you for agreeing to do this interview that was designed to assist in understanding the needs to increase HIV/AIDS prevention and care activities in your District Conference. **Do you mind if this interview is taped? This question will be repeated after the recorder is turned on.**

The responses will be used to assist with understanding data on an Annual Conference Level. Please note that this data is being collected as a part of a Doctor of Ministry project with United Theological Seminary as well as HIV/AIDS project activities of Pilgrim Community Outreach Corporation. **Do you have any objection to this interview transcript being used for these purposes?**

For more information please contact Rev. Cassandra Sparrow at (_____)_____.

1. **Do you recall the HIV/AIDS Survey disseminated at the 2003 Midyear conference in Raleigh, NC? Did you complete the survey?**

Preliminary assessment shows that approximately 80 surveys were received from members of the Virginia Annual Conference.

2. **On a scale of 1-5 where 1 is low and 5 is high, how would you rate the overall readiness of churches on your District to address HIV/AIDS? Please explain your response.**

3. **Are you aware of any churches or agencies in your District engaged in efforts to address HIV/AIDS?**

4. **Has there ever been a Health Presentation at a District Conference under your leadership?**
How long ago? Do you recall, what areas were addressed? HIV/AIDS?

5. **What do you think the major opportunities are to implementing a HIV/AIDS awareness project in your District Conference?**

12. **What do you think the major challenges are to implementing a HIV/AIDS awareness project in your in your District Conference?**

13. **How open are you in your position as Presiding Elder to help raise awareness on HIV/AIDS?**
If open, what could assist you? Either way, are there any concerns or conditions that might hinder your involvement?

Thank you for your contribution to this project.

WESTERN NORTH CAROLINA
PASTORAL LEADERSHIP
IN-DEPTH INTERVIEW
(V.2)

Date Interview Completed_____ Start Time _____End Time_____

Interviewer _____

Interview # _____

Conduct Method: In-person_____Phone_____ Other (Please specify)_____

Greetings. Thank you for agreeing to do this interview that was designed to assist in understanding the needs to increase HIV/AIDS prevention and care activities in local church. **Do you mind if this interview is taped? This question will be repeated after the recorder is turned on.**

The responses will be used to assist with understanding data on an Annual Conference Level. Please note that this data is being collected as a part of a Doctor of Ministry project with United Theological Seminary as well as HIV/AIDS project activities of Pilgrim Community Outreach Corporation. **Do you have any objection to this interview transcript being used for these purposes?**

For more information please contact Rev. Cassandra Sparrow at (XXX) XXX-XXXX.

1. **Do you recall the HIV/AIDS Survey disseminated at the 2003 Midyear conference in Raleigh, NC?**

   Did you complete the survey?

Preliminary assessment shows that approximately 86 surveys were received from members of the Western North Carolina Annual Conference.

2. **On a scale of 1-5 where 1 is low and 5 is high, how would you rate the overall readiness of the church you pastor to address HIV/AIDS?**

   Please explain your response.

3. **Are you aware of any other churches or agencies in your area engaged in efforts to address HIV/AIDS?**

4. **Has there ever been a Health Presentation at the church under your leadership?**

   How long ago? Do you recall, what areas were addressed? HIV/AIDS?

5. **What do you think the major <u>opportunities</u> are to implementing HIV/AIDS awareness project in your local church?**

14. **What do you think the major challenges are to HIV/AIDS awareness project in your local church?**

15. **How open are you in your position as Pastor to help raise awareness on HIV/AIDS?**

If open, what could assist you?

Either way, are there any concerns or conditions that might hinder your involvement?

Thank you for your contribution to this project.

BACKGROUND INFORMATION

ITEM	RESPONSE	COMMENTS
Length of Time Pastor at Current Charge		
Length of Time in Pastorate (Any Location)		
Length of Time in Ordained Ministry (1st Ordination)		
Episcopal Districts Served in to date (As clergy & lay)		
Annual Conferences Served in to date (Including current)		
How would you classify the location of your church? (Urban, Suburban, Rural)		
Size of congregation **<100, 100-300, 400-500**		
Highest Educational Level Achieved		
Gender		
Race		

Thank you for your contribution to this project.

APPENDIX E

PILOT STUDY RESULTS AND OTHER SELECTED QUANTITATIVE DATA

Pilot Study Results

Outcomes

Pilot Test

The pilot test was completed with 12 persons using a convenient sampling method. The readability and reliability of the survey was also calculated. This section is divided into two parts: 1) Quantitative Data Results for Research Question One and 2) Quantitative Data Results for Research Question Two.

Quantitative Data Results for Research Question One

The first research question was: to what extent have members ever attended a health and/or HIV/AIDS presentation or workshop, ever reviewed HIV/AIDS literature, shared or heard a clergyperson discuss HIV/AIDS with the church congregation, and are aware of how HIV/AIDS is transmitted as related to their a) annual conference affiliation, b) clergy or lay status, c) age and d) gender.

Pilot Test

Overview of Survey Respondents

Annual Conference Representation

Table 1 Pilot Annual Conference Frequency

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Washington	12	100.0	100.0	100.0

Clergy or Lay Status

Table 2. Pilot Clergy or Lay Frequency

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Lay	11	91.7	91.7	91.7
	Missing	1	8.3	8.3	100.0
	Total	12	100.0	100.0	

Age

Table 3. Pilot Age Frequency

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	26.00	1	8.3	8.3	8.3
	37.00	1	8.3	8.3	16.7
	50.00	1	8.3	8.3	25.0
	53.00	1	8.3	8.3	33.3
	56.00	1	8.3	8.3	41.7
	62.00	2	16.7	16.7	58.3
	63.00	1	8.3	8.3	66.7
	70.00	1	8.3	8.3	75.0
	73.00	1	8.3	8.3	83.3
	Missing	2	16.7	16.7	100.0
	Total	12	100.0	100.0	

Gender

Table 4. Pilot Gender Frequency

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	5	41.7	41.7	41.7
	Female	7	58.3	58.3	100.0
	Total	12	100.0	100.0	

Ethnic/Racial Group

Table 5. Pilot Race/Ethnic Group Frequency

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Black	7	58.3	58.3	58.3
	Missing	5	41.7	41.7	100.0
	Total	12	100.0	100.0	

Ever attended an health presentation or workshop (Survey Question 3)

Second Episcopal District Event

Table 6. Attended Health Presentation/Workshop in 2nd E.D.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	3	25.0	25.0	25.0
	No	8	66.7	66.7	91.7
	Missing	1	8.3	8.3	100.0
	Total	12	100.0	100.0	

District Conference

Table 7. Attended Health Presentation/Workshop in District Conference

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	3	25.0	25.0	25.0
	No	7	58.3	58.3	83.3
	Missing	2	16.7	16.7	100.0
	Total	12	100.0	100.0	

Local Church

Table 8. Attended Health Presentation/Workshop in Local Church

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	8	66.7	66.7	66.7
	No	3	25.0	25.0	91.7
	Missing	1	8.3	8.3	100.0
	Total	12	100.0	100.0	

Ever attended an HIV/AIDS presentation or workshop (Survey Question 4)

Second Episcopal District Event

Table 9. Attended HIV/AIDS/Workshop Presentation in 2nd E.D.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	3	25.0	25.0	25.0
	No	8	66.7	66.7	91.7
	Missing	1	8.3	8.3	100.0
	Total	12	100.0	100.0	

District Conference

Table 10. Attended HIV/AIDS Presentation/Workshop in District Conference

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	3	25.0	25.0	25.0
	No	7	58.3	58.3	83.3
	Missing	2	16.7	16.7	100.0
	Total	12	100.0	100.0	

Local Church

Table 11. Attended HIV/AIDS Presentation/Workshop in Local Church

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	5	41.7	41.7	41.7
	No	5	41.7	41.7	83.3
	Missing	2	16.7	16.7	100.0
	Total	12	100.0	100.0	

Ever attended an HIV/AIDS presentation or workshop (Question 5)

Overall Percentage Attended

Table 12. Have Ever Attended a HIV/AIDS Presentation/Workshop (5b)

		Frequency	Percent	Valid Percent	Cumulative Percent
	Yes	4	33.3	33.3	33.3
	No	5	41.7	41.7	75.0
	Missing	3	25.0	25.0	100.0
	Total	12	100.0	100.0	

When

Table 13. If, Yes in 5b, WHEN attended HIV/AIDS Presentation/Workshop

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2003	1	8.3	8.3	8.3
	2001	2	16.7	16.7	25.0
	Missing	9	75.0	75.0	100.0
	Total	12	100.0	100.0	

Where

Table 14. If, Yes in 5c, WHERE attended HIV/AIDS Presentation/Workshop

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Church	2	16.7	16.7	16.7
	Job	2	16.7	16.7	33.3
	City/State Given	1	8.3	8.3	41.7
	Missing	7	58.3	58.3	100.0
	Total	12	100.0	100.0	

Ever reviewed any HIV/AIDS literature[1]

(Question 6)

Pamphlets

Table 15. Ever Reviewed Pamphlets on HIV/AIDS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	11	91.7	91.7	91.7
	Missing	1	8.3	8.3	100.0
	Total	12	100.0	100.0	

Fact Sheets

Table 16. Pilot Ever Reviewed Fact Sheets on HIV/AIDS Frequency

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	8	66.7	66.7	66.7
	Missing	4	33.3	33.3	100.0
	Total	12	100.0	100.0	

Brochures

Table 17. Pilot Ever Reviewed Brochures on HIV/AIDS Frequency

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	9	75.0	75.0	75.0
	Missing	3	25.0	25.0	100.0
	Total	12	100.0	100.0	

[1]Only four types of literature reviewed in the survey instrument used in this project. A survey instrument prepared for Southern African included other means such as billboards, videotapes etc.

Videos

Table 18. Pilot Ever Reviewed Videos on HIV/AIDS Frequency

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	4	33.3	33.3	33.3
	Missing	8	66.7	66.7	100.0
	Total	12	100.0	100.0	

How HIV/AIDS can be transmitted[2] (Question 10)

Table 19. Pilot HIV/AIDS Transmitted by Kissing Frequency

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	8	66.7	66.7	66.7
	Missing	4	33.3	33.3	100.0
	Total	12	100.0	100.0	

Table 20. Pilot HIV/AIDS Transmitted by Sexual Contact Frequency

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	12	100.0	100.0	100.0

Table 21. Pilot HIV/AIDS Transmitted by IV Needle Sharing Frequency

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	12	100.0	100.0	100.0

Table 22. Pilot HIV/AIDS Transmitted by Blood Transfusions Frequency

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	12	100.0	100.0	100.0

Table 23. Pilot HIV/AIDS Transmitted by Toilet Frequency

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	4	33.3	33.3	33.3
	Missing	8	66.7	66.7	100.0
	Total	12	100.0	100.0	

[2] The actual survey item (number ten) asked respondents to check all the ways that HIV/AIDS can be transmitted. In reality HIV is transmitted and AIDS may develop over time after the virus has been implanted into a host. A more accurate wording would have asked how HIV can be transmitted. However, to avoid any confusion due to common referral to both HIV and AIDS interchangeably, "HIV/AIDS" was used in the survey instrument.

Quantitative Data Results for Research Question Two

The second research question was: what is the likelihood that members would support an HIV/AIDS church-based awareness project among African Americans and in Southern Africa as related to their a) annual conference affiliation, b) clergy or lay status, c) age and d) gender. Research question two included quantitative and qualitative data to assess the readiness of the Second Episcopal District clergy leadership (i.e., Presiding Elders and Pastors) to address HIV/AIDS and related issues.

Likelihood to support an HIV/AIDS church-based awareness project focused on both African Americans and Southern Africa (Questions 7 and 8)

The intent of this question was to obtain an indication of the number of persons who would be open to supporting both domestic and international HIV/AIDS awareness projects. The responses very likely and somewhat likely were used to indicate the likelihood to support such projects.

Likelihood to support an HIV/AIDS church-based awareness project focused on African Americans (Question 7)

Pilot Likelihood to Support church-based HIV/AIDS Awareness African Americans

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very Likely	10	83.3	83.3	83.3
	Somewhat Likely	2	16.7	16.7	100.0
	Total	12	100.0	100.0	

Likelihood to support an HIV/AIDS church-based awareness project focused on Southern Africa (Question 8)

Pilot Likelihood to Support church-based HIV/AIDS Awareness Southern African Project

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very Likely	8	66.7	66.7	66.7
	Somewhat Likely	2	16.7	16.7	83.3
	Unlikely	1	8.3	8.3	91.7
	Unsure	1	8.3	8.3	100.0
	Total	12	100.0	100.0	

Reliability Output

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  /FORMAT= AVALUE TABLES
  /STATISTIC=CHISQ
  /CELLS= COUNT ROW COLUMN TOTAL
  /COUNT ROUND CELL
  /BARCHART .
```

Crosstabs

Notes

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Comments		
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	Filter	<none>
	Weight	<none>
	Split File	<none>
	N of Rows in Working Data File	471
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	Cases Used	Statistics for each table are based on all the cases with valid data in the specified range(s) for all variables in each table.
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	Processor Time	0:00:02.52

Annual Conference * Gender

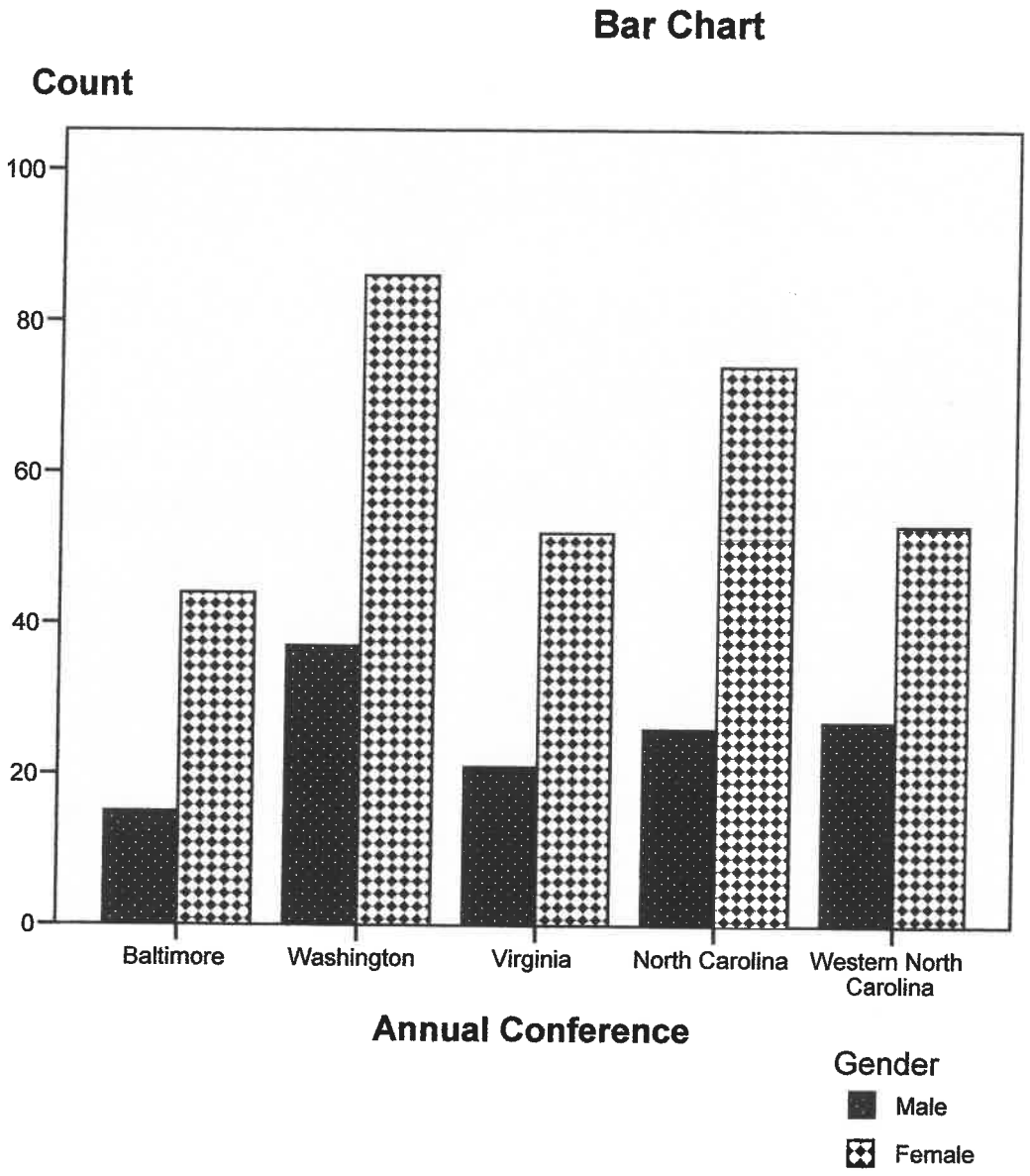
Crosstab

			Gender		Total
			Male	Female	Male
Annual Conference	Baltimore	Count	15	44	59
		% within Annual Conference	25.4%	74.6%	100.0%
		% within Gender	11.9%	14.2%	13.6%
		% of Total	3.4%	10.1%	13.6%
	Washington	Count	37	86	123
		% within Annual Conference	30.1%	69.9%	100.0%
		% within Gender	29.4%	27.8%	28.3%
		% of Total	8.5%	19.8%	28.3%
	Virginia	Count	21	52	73
		% within Annual Conference	28.8%	71.2%	100.0%
		% within Gender	16.7%	16.8%	16.8%
		% of Total	4.8%	12.0%	16.8%
	North Carolina	Count	26	74	100
		% within Annual Conference	26.0%	74.0%	100.0%
		% within Gender	20.6%	23.9%	23.0%
		% of Total	6.0%	17.0%	23.0%
	Western North Carolina	Count	27	53	80
		% within Annual Conference	33.8%	66.3%	100.0%
		% within Gender	21.4%	17.2%	18.4%
		% of Total	6.2%	12.2%	18.4%
Total		Count	126	309	435
		% within Annual Conference	29.0%	71.0%	100.0%
		% within Gender	100.0%	100.0%	100.0%
		% of Total	29.0%	71.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	1.753(a)	4	.781
Likelihood Ratio	1.745	4	.783
Linear-by-Linear Association	.350	1	.554
N of Valid Cases	435		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 17.09.


Bar Chart
Count
100
80
60
40
20
0
Baltimore
Washington
Virginia
North Carolina
Western North Carolina
Annual Conference
Gender
Male
Female

Annual Conference * pastyr9b

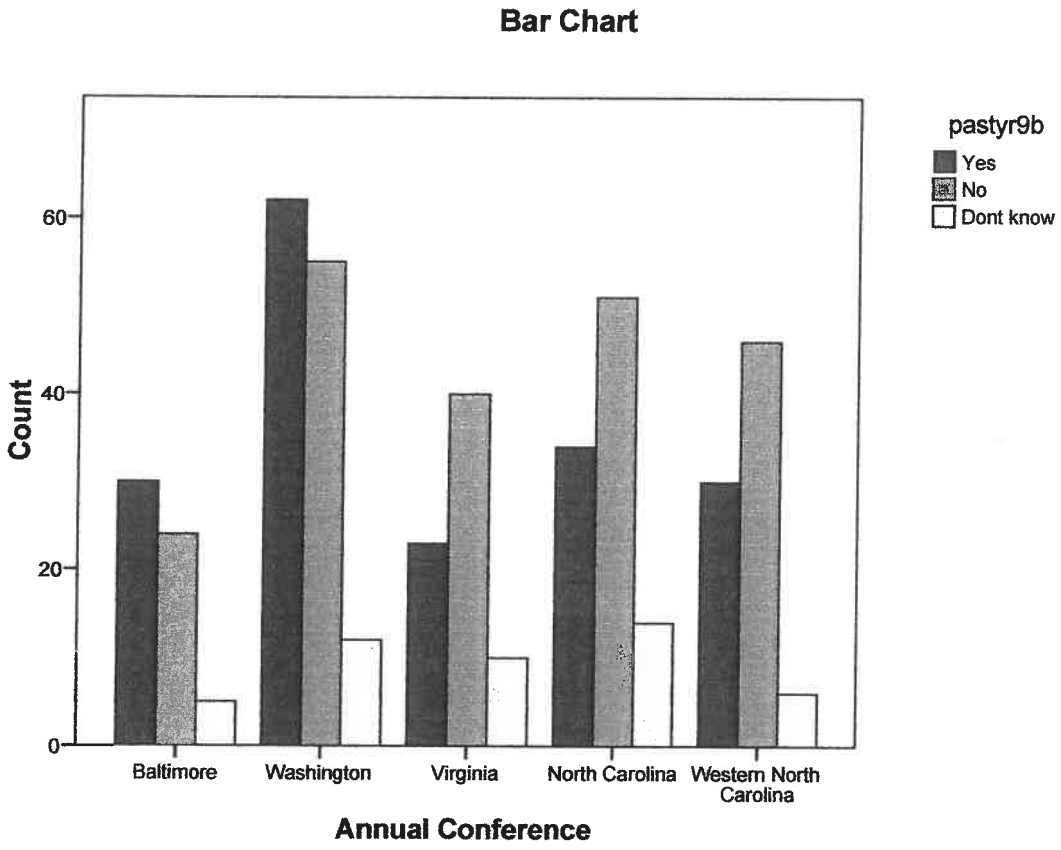
Crosstab

			pastyr9b			Total
			Yes	No	Don't know	Yes
Annual Conference	Baltimore	Count	30	24	5	59
		% within Annual Conference	50.8%	40.7%	8.5%	100.0%
		% within pastyr9b	16.8%	11.1%	10.6%	13.3%
		% of Total	6.8%	5.4%	1.1%	13.3%
	Washington	Count	62	55	12	129
		% within Annual Conference	48.1%	42.6%	9.3%	100.0%
		% within pastyr9b	34.6%	25.5%	25.5%	29.2%
		% of Total	14.0%	12.4%	2.7%	29.2%
	Virginia	Count	23	40	10	73
		% within Annual Conference	31.5%	54.8%	13.7%	100.0%
		% within pastyr9b	12.8%	18.5%	21.3%	16.5%
		% of Total	5.2%	9.0%	2.3%	16.5%
	North Carolina	Count	34	51	14	99
		% within Annual Conference	34.3%	51.5%	14.1%	100.0%
		% within pastyr9b	19.0%	23.6%	29.8%	22.4%
		% of Total	7.7%	11.5%	3.2%	22.4%
	Western North Carolina	Count	30	46	6	82
		% within Annual Conference	36.6%	56.1%	7.3%	100.0%
		% within pastyr9b	16.8%	21.3%	12.8%	18.6%
		% of Total	6.8%	10.4%	1.4%	18.6%
Total		Count	179	216	47	442
		% within Annual Conference	40.5%	48.9%	10.6%	100.0%
		% within pastyr9b	100.0%	100.0%	100.0%	100.0%
		% of Total	40.5%	48.9%	10.6%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.567(a)	8	.128
Likelihood Ratio	12.533	8	.129
Linear-by-Linear Association	4.040	1	.044
N of Valid Cases	442		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 6.27.



Annual Conference * age2

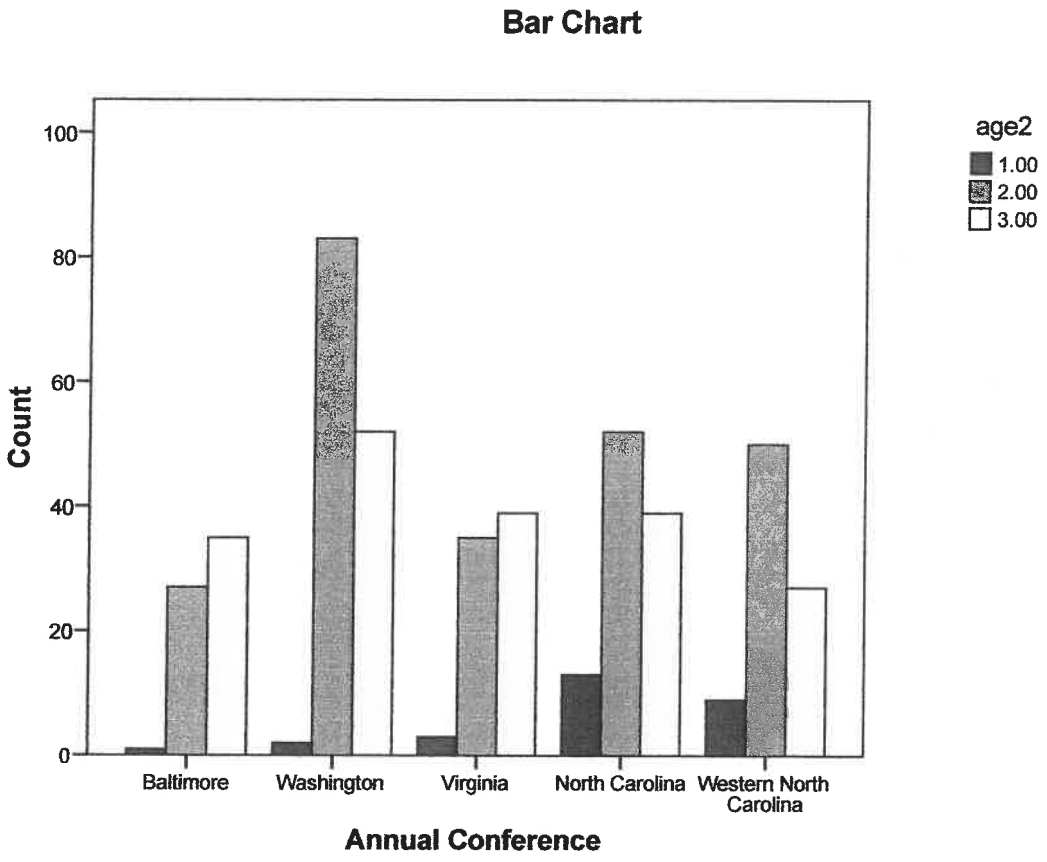
Crosstab

			age2			Total
			1.00	2.00	3.00	1.00
Annual Conference	Baltimore	Count	1	27	35	63
		% within Annual Conference	1.6%	42.9%	55.6%	100.0%
		% within age2	3.6%	10.9%	18.2%	13.5%
		% of Total	.2%	5.8%	7.5%	13.5%
	Washington	Count	2	83	52	137
		% within Annual Conference	1.5%	60.6%	38.0%	100.0%
		% within age2	7.1%	33.6%	27.1%	29.3%
		% of Total	.4%	17.8%	11.1%	29.3%
	Virginia	Count	3	35	39	77
		% within Annual Conference	3.9%	45.5%	50.6%	100.0%
		% within age2	10.7%	14.2%	20.3%	16.5%
		% of Total	.6%	7.5%	8.4%	16.5%
	North Carolina	Count	13	52	39	104
		% within Annual Conference	12.5%	50.0%	37.5%	100.0%
		% within age2	46.4%	21.1%	20.3%	22.3%
		% of Total	2.8%	11.1%	8.4%	22.3%
	Western North Carolina	Count	9	50	27	86
		% within Annual Conference	10.5%	58.1%	31.4%	100.0%
		% within age2	32.1%	20.2%	14.1%	18.4%
		% of Total	1.9%	10.7%	5.8%	18.4%
Total		Count	28	247	192	467
		% within Annual Conference	6.0%	52.9%	41.1%	100.0%
		% within age2	100.0%	100.0%	100.0%	100.0%
		% of Total	6.0%	52.9%	41.1%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	29.199(a)	8	.000
Likelihood Ratio	29.721	8	.000
Linear-by-Linear Association	12.580	1	.000
N of Valid Cases	467		

a 2 cells (13.3%) have expected count less than 5. The minimum expected count is 3.78.



Clergy or Lay * Gender

Crosstab

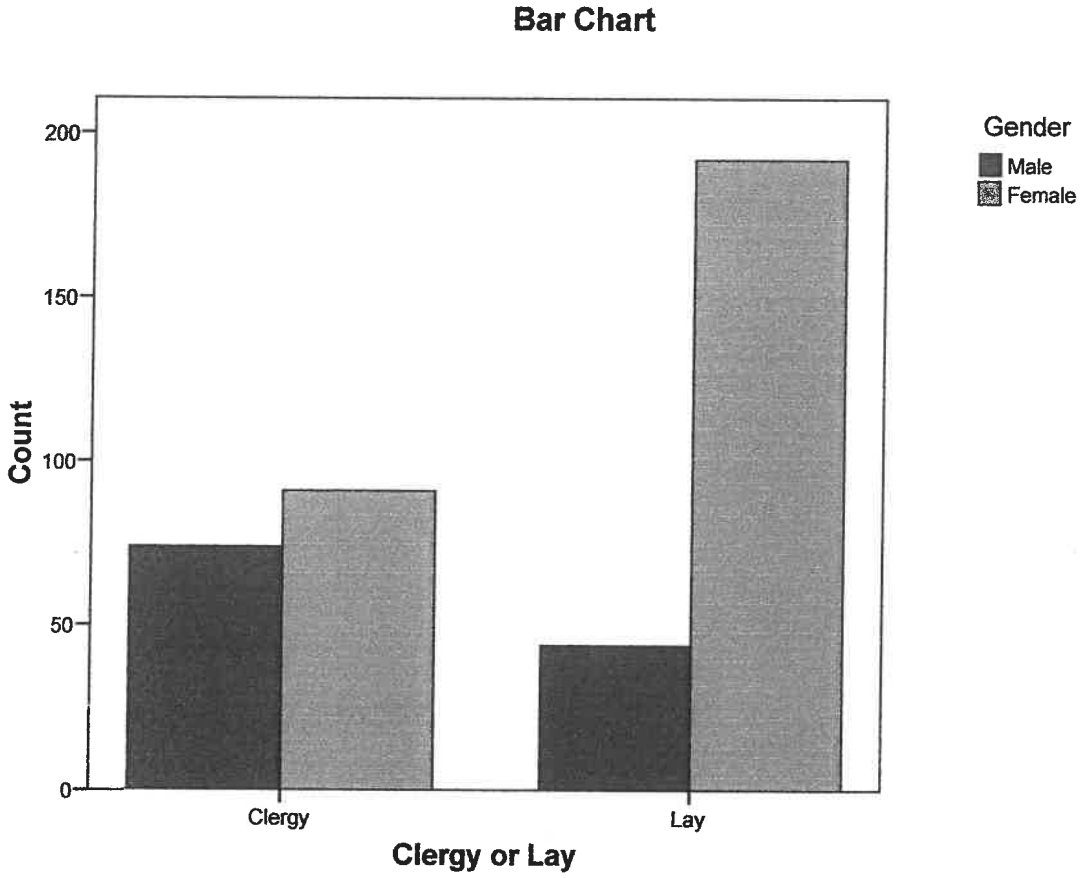
			Gender		Total
			Male	Female	Male
Clergy or Lay	Clergy	Count	74	91	165
		% within Clergy or Lay	44.8%	55.2%	100.0%
		% within Gender	62.7%	32.2%	41.1%
		% of Total	18.5%	22.7%	41.1%
	Lay	Count	44	192	236
		% within Clergy or Lay	18.6%	81.4%	100.0%
		% within Gender	37.3%	67.8%	58.9%
		% of Total	11.0%	47.9%	58.9%
Total		Count	118	283	401
		% within Clergy or Lay	29.4%	70.6%	100.0%
		% within Gender	100.0%	100.0%	100.0%
		% of Total	29.4%	70.6%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	32.109(b)	1	.000		
Continuity Correction(a)	30.859	1	.000		
Likelihood Ratio	31.927	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	32.028	1	.000		
N of Valid Cases	401				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 48.55.


Bar Chart
Count
200
150
100
50
0
Clergy
Lay
Clergy or Lay
Gender
Male
Female

Clergy or Lay * pastyr9b

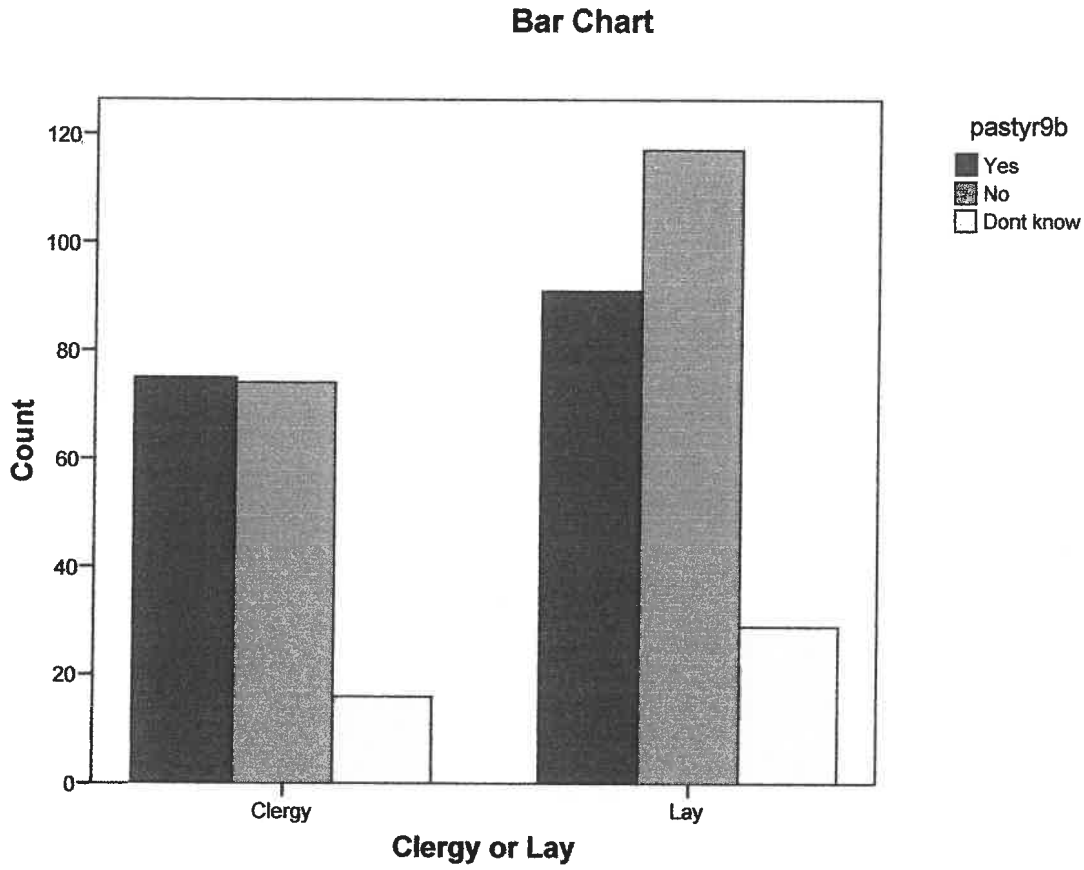
Crosstab

			pastyr9b			Total
			Yes	No	Don't know	Yes
Clergy or Lay	Clergy	Count	75	74	16	165
		% within Clergy or Lay	45.5%	44.8%	9.7%	100.0%
		% within pastyr9b	45.2%	38.7%	35.6%	41.0%
		% of Total	18.7%	18.4%	4.0%	41.0%
	Lay	Count	91	117	29	237
		% within Clergy or Lay	38.4%	49.4%	12.2%	100.0%
		% within pastyr9b	54.8%	61.3%	64.4%	59.0%
		% of Total	22.6%	29.1%	7.2%	59.0%
Total		Count	166	191	45	402
		% within Clergy or Lay	41.3%	47.5%	11.2%	100.0%
		% within pastyr9b	100.0%	100.0%	100.0%	100.0%
		% of Total	41.3%	47.5%	11.2%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	2.152(a)	2	.341
Likelihood Ratio	2.153	2	.341
Linear-by-Linear Association	2.058	1	.151
N of Valid Cases	402		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 18.47.


Bar Chart
pastyr9b
Yes
No
Dont know
Count
120
100
80
60
40
20
0
Clergy
Lay
Clergy or Lay

Clergy or Lay * age2

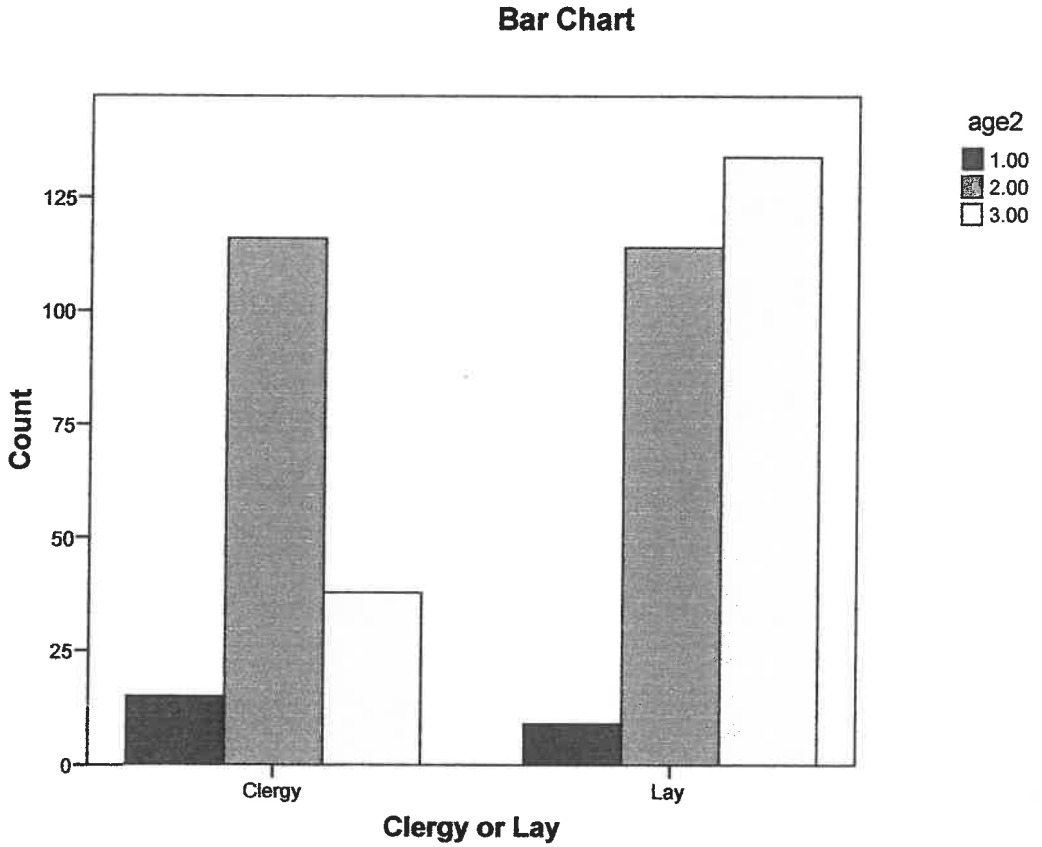
Crosstab

			age2			Total
			1.00	2.00	3.00	1.00
Clergy or Lay	Clergy	Count	15	116	38	169
		% within Clergy or Lay	8.9%	68.6%	22.5%	100.0%
		% within age2	62.5%	50.4%	22.1%	39.7%
		% of Total	3.5%	27.2%	8.9%	39.7%
	Lay	Count	9	114	134	257
		% within Clergy or Lay	3.5%	44.4%	52.1%	100.0%
		% within age2	37.5%	49.6%	77.9%	60.3%
		% of Total	2.1%	26.8%	31.5%	60.3%
Total		Count	24	230	172	426
		% within Clergy or Lay	5.6%	54.0%	40.4%	100.0%
		% within age2	100.0%	100.0%	100.0%	100.0%
		% of Total	5.6%	54.0%	40.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	38.566(a)	2	.000
Likelihood Ratio	40.006	2	.000
Linear-by-Linear Association	36.773	1	.000
N of Valid Cases	426		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 9.52.




```
DATASET NAME DataSet2 WINDOW=FRONT.
DATASET ACTIVATE DataSet1.
DATASET CLOSE DataSet2.
RELIABILITY
  /VARIABLES=hiv2nd4a hivloc4b hivdis4c hapres5a
  /SCALE('ALL VARIABLES')  ALL/MODEL=ALPHA
  /STATISTICS=CORR
  /SUMMARY=MEANS CORR .
```

Reliability

Notes

Output Created		
Comments		
Input	Data	
	Active Dataset	DataSet1
	Filter	<none>
	Weight	<none>
	Split File	<none>
	N of Rows in Working Data File	471
	Matrix Input	
Missing Value Handling	Definition of Missing	User-defined missing values are treated as missing.
	Cases Used	Statistics are based on all cases with valid data for all variables in the procedure.
Syntax		RELIABILITY /VARIABLES=hiv2nd4a hivloc4b hivdis4c hapres5a /SCALE('ALL VARIABLES') ALL/MODEL=ALPHA /STATISTICS=CORR /SUMMARY=MEANS CORR .
Resources	Elapsed Time	0:00:00.34
	Memory Available	786944 bytes
	Largest Contiguous Area	786944 bytes
	Workspace Required	344 bytes
	Processor Time	0:00:00.06

Scale: ALL VARIABLES

Case Processing Summary

		N	%
Cases	Valid	304	64.5
	Excluded(a)	167	35.5
	Total	471	100.0

a Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.757	.756	4

Inter-Item Correlation Matrix

	Attended HIV/AIDS/Workshop Presentation in 2nd E.D.	Attended HIV/AIDS Presentation/Workshop in Local Church	Attended HIV/AIDS Presentation/ Workshop in District Conference	Have Ever Attended a HIV/AIDS Presentation/ Workshop
Attended HIV/AIDS/Workshop Presentation in 2nd E.D.	1.000	.455	.646	.275
Attended HIV/AIDS Presentation/Workshop in Local Church	.455	1.000	.470	.474
Attended HIV/AIDS Presentation/Workshop in District Conference	.646	.470	1.000	.296
Have Ever Attended a HIV/AIDS Presentation/Workshop	.275	.474	.296	1.000

Summary Item Statistics

	Mean	Minimum	Maximum	Range	Maximum / Minimum	Variance	N of Items
Item Means	1.536	1.309	1.668	.359	1.274	.026	4
Inter-Item Correlations	.436	.275	.646	.371	2.345	.017	4

Supplemental Quantitative Results

```
CROSSTABS
  /TABLES=anncon1a  BY hlt2nd3a hltloc3b hltdis3c hiv2nd4a hivloc4b
hivdis4c
  /FORMAT= AVALUE TABLES
  /STATISTIC=CHISQ
  /CELLS= COUNT ROW COLUMN TOTAL
  /COUNT ROUND CELL
  /BARCHART .
```

Crosstabs

Notes

Output Created		
Comments		
Input	Data	
	Active Dataset	DataSet1
	Filter	<none>
	Weight	<none>
	Split File	<none>
	N of Rows in Working Data File	471
Missing Value Handling	Definition of Missing	User-defined missing values are treated as missing.
	Cases Used	Statistics for each table are based on all the cases with valid data in the specified range(s) for all variables in each table.
Syntax		CROSSTABS /TABLES=anncon1a BY hlt2nd3a hltloc3b hltdis3c hiv2nd4a hivloc4b hivdis4c /FORMAT= AVALUE TABLES /STATISTIC=CHISQ /CELLS= COUNT ROW COLUMN TOTAL /COUNT ROUND CELL /BARCHART .
Resources	Elapsed Time	0:00:02.61
	Dimensions Requested	2
	Cells Available	174876
	Processor Time	0:00:02.47

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Annual Conference * Attended Hlth Presentation/Workshop in 2nd E.D.	435	92.4%	36	7.6%	471	100.0%
Annual Conference * Attended Hlth Presentation/Workshop in Local Church	428	90.9%	43	9.1%	471	100.0%
Annual Conference * Attended Hlth Presentation/Workshop in District Conference	393	83.4%	78	16.6%	471	100.0%
Annual Conference * Attended HIV/AIDS/Workshop Presentation in 2nd E.D.	423	89.8%	48	10.2%	471	100.0%
Annual Conference * Attended HIV/AIDS Presentation/Workshop in Local Church	412	87.5%	59	12.5%	471	100.0%
Annual Conference * Attended HIV/AIDS Presentation/Workshop in District Conference	368	78.1%	103	21.9%	471	100.0%

Annual Conference * Attended Health Presentation/Workshop in 2nd Episcopal District

Crosstab

			Attended Health Presentation/Workshop in 2nd E.D.		Total
			Yes	No	Yes
Annual Conference	Baltimore	Count	38	19	57
		% within Annual Conference	66.7%	33.3%	100.0%
		% within Attended Health Presentation/Workshop in 2nd E.D.	13.5%	12.3%	13.1%
		% of Total	8.7%	4.4%	13.1%
	Washington	Count	90	38	128
		% within Annual Conference	70.3%	29.7%	100.0%
		% within Attended Health Presentation/Workshop in 2nd E.D.	32.0%	24.7%	29.4%
		% of Total	20.7%	8.7%	29.4%
	Virginia	Count	44	27	71
		% within Annual Conference	62.0%	38.0%	100.0%
		% within Attended Health Presentation/Workshop in 2nd E.D.	15.7%	17.5%	16.3%
		% of Total	10.1%	6.2%	16.3%
	North Carolina	Count	55	42	97
		% within Annual Conference	56.7%	43.3%	100.0%
		% within Attended Health Presentation/Workshop in 2nd E.D.	19.6%	27.3%	22.3%
		% of Total	12.6%	9.7%	22.3%
	Western North Carolina	Count	54	28	82
		% within Annual Conference	65.9%	34.1%	100.0%
		% within Attended Health Presentation/Workshop in 2nd E.D.	19.2%	18.2%	18.9%
		% of Total	12.4%	6.4%	18.9%
Total		Count	281	154	435
		% within Annual Conference	64.6%	35.4%	100.0%
		% within Attended Health Presentation/Workshop in 2nd E.D.	100.0%	100.0%	100.0%
		% of Total	64.6%	35.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	4.850(a)	4	.303
Likelihood Ratio	4.826	4	.306
Linear-by-Linear Association	1.304	1	.253
N of Valid Cases	435		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 20.18.

Annual Conference * Attended Health Presentation/Workshop in Local Church

Crosstab

			Attended Health Presentation/Workshop in Local Church		Total
			Yes	No	Yes
Annual Conference	Baltimore	Count	43	10	53
		% within Annual Conference	81.1%	18.9%	100.0%
		% within Attended Health Presentation/Workshop in Local Church	12.6%	11.4%	12.4%
		% of Total	10.0%	2.3%	12.4%
	Washington	Count	98	27	125
		% within Annual Conference	78.4%	21.6%	100.0%
		% within Attended Health Presentation/Workshop in Local Church	28.8%	30.7%	29.2%
		% of Total	22.9%	6.3%	29.2%
	Virginia	Count	63	13	76
		% within Annual Conference	82.9%	17.1%	100.0%
		% within Attended Health Presentation/Workshop in Local Church	18.5%	14.8%	17.8%
		% of Total	14.7%	3.0%	17.8%
	North Carolina	Count	65	27	92
		% within Annual Conference	70.7%	29.3%	100.0%
		% within Attended Health Presentation/Workshop in Local Church	19.1%	30.7%	21.5%
		% of Total	15.2%	6.3%	21.5%
	Western North Carolina	Count	71	11	82
		% within Annual Conference	86.6%	13.4%	100.0%
		% within Attended Health Presentation/Workshop in Local Church	20.9%	12.5%	19.2%
		% of Total	16.6%	2.6%	19.2%
Total		Count	340	88	428
		% within Annual Conference	79.4%	20.6%	100.0%
		% within Attended Health Presentation/Workshop in Local Church	100.0%	100.0%	100.0%
		% of Total	79.4%	20.6%	100.0%

Chi-Square Tests

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	7.644(a)	4	.106
Likelihood Ratio	7.570	4	.109
Linear-by-Linear Association	.080	1	.778
N of Valid Cases	428		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 10.90.

Annual Conference * Attended Health Presentation/Workshop in District Conference

Crosstab

			Attended Health Presentation/Workshop in District Conference		Total
			Yes	No	Yes
Annual Conference	Baltimore	Count	35	15	50
		% within Annual Conference	70.0%	30.0%	100.0%
		% within Attended Health Presentation/Workshop in District Conference	13.1%	12.0%	12.7%
		% of Total	8.9%	3.8%	12.7%
	Washington	Count	86	30	116
		% within Annual Conference	74.1%	25.9%	100.0%
		% within Attended Health Presentation/Workshop in District Conference	32.1%	24.0%	29.5%
		% of Total	21.9%	7.6%	29.5%
	Virginia	Count	46	19	65
		% within Annual Conference	70.8%	29.2%	100.0%
		% within Attended Health Presentation/Workshop in District Conference	17.2%	15.2%	16.5%
		% of Total	11.7%	4.8%	16.5%
	North Carolina	Count	55	34	89
		% within Annual Conference	61.8%	38.2%	100.0%
		% within Attended Health Presentation/Workshop in District Conference	20.5%	27.2%	22.6%
		% of Total	14.0%	8.7%	22.6%
	Western North Carolina	Count	46	27	73
		% within Annual Conference	63.0%	37.0%	100.0%
		% within Attended Health Presentation/Workshop in District Conference	17.2%	21.6%	18.6%
		% of Total	11.7%	6.9%	18.6%
Total		Count	268	125	393
		% within Annual Conference	68.2%	31.8%	100.0%
		% within Attended Health Presentation/Workshop in District Conference	100.0%	100.0%	100.0%
		% of Total	68.2%	31.8%	100.0%

Chi-Square Tests

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	4.745(a)	4	.314
Likelihood Ratio	4.745	4	.314
Linear-by-Linear Association	3.185	1	.074
N of Valid Cases	393		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 15.90.

Annual Conference * Attended HIV/AIDS Workshop Presentation in 2nd Episcopal District

Crosstab

			Attended HIV/AIDS Workshop Presentation in 2nd E.D.		Total
			Yes	No	Yes
Annual Conference	Baltimore	Count	23	31	54
		% within Annual Conference	42.6%	57.4%	100.0%
		% within Attended HIV/AIDS Workshop Presentation in 2nd E.D.	13.5%	12.3%	12.8%
		% of Total	5.4%	7.3%	12.8%
	Washington	Count	48	71	119
		% within Annual Conference	40.3%	59.7%	100.0%
		% within Attended HIV/AIDS Workshop Presentation in 2nd E.D.	28.2%	28.1%	28.1%
		% of Total	11.3%	16.8%	28.1%
	Virginia	Count	34	41	75
		% within Annual Conference	45.3%	54.7%	100.0%
		% within Attended HIV/AIDS Workshop Presentation in 2nd E.D.	20.0%	16.2%	17.7%
		% of Total	8.0%	9.7%	17.7%
	North Carolina	Count	37	62	99
		% within Annual Conference	37.4%	62.6%	100.0%
		% within Attended HIV/AIDS Workshop Presentation in 2nd E.D.	21.8%	24.5%	23.4%
		% of Total	8.7%	14.7%	23.4%
	Western North Carolina	Count	28	48	76
		% within Annual Conference	36.8%	63.2%	100.0%
		% within Attended HIV/AIDS Workshop Presentation in 2nd E.D.	16.5%	19.0%	18.0%
		% of Total	6.6%	11.3%	18.0%
Total		Count	170	253	423
		% within Annual Conference	40.2%	59.8%	100.0%
		% within Attended HIV/AIDS Workshop Presentation in 2nd E.D.	100.0%	100.0%	100.0%
		% of Total	40.2%	59.8%	100.0%

Chi-Square Tests

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	1.637(a)	4	.802
Likelihood Ratio	1.633	4	.803
Linear-by-Linear Association	.638	1	.424
N of Valid Cases	423		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 21.70.

Annual Conference * Attended HIV/AIDS Presentation/Workshop in Local Church

Crosstab

			Attended HIV/AIDS Presentation/Workshop in Local Church			Total
			Yes	No	9.00	Yes
Annual Conference	Baltimore	Count	36	18	0	54
		% within Annual Conference	66.7%	33.3%	.0%	100.0%
		% within Attended HIV/AIDS Presentation/Workshop in Local Church	15.7%	9.9%	.0%	13.1%
		% of Total	8.7%	4.4%	.0%	13.1%
	Washington	Count	65	54	0	119
		% within Annual Conference	54.6%	45.4%	.0%	100.0%
		% within Attended HIV/AIDS Presentation/Workshop in Local Church	28.4%	29.7%	.0%	28.9%
		% of Total	15.8%	13.1%	.0%	28.9%
	Virginia	Count	41	25	0	66
		% within Annual Conference	62.1%	37.9%	.0%	100.0%
		% within Attended HIV/AIDS Presentation/Workshop in Local Church	17.9%	13.7%	.0%	16.0%
		% of Total	10.0%	6.1%	.0%	16.0%
	North Carolina	Count	43	51	0	94
		% within Annual Conference	45.7%	54.3%	.0%	100.0%
		% within Attended HIV/AIDS Presentation/Workshop in Local Church	18.8%	28.0%	.0%	22.8%
		% of Total	10.4%	12.4%	.0%	22.8%
	Western North Carolina	Count	44	34	1	79
		% within Annual Conference	55.7%	43.0%	1.3%	100.0%
		% within Attended HIV/AIDS Presentation/Workshop in Local Church	19.2%	18.7%	100.0%	19.2%
		% of Total	10.7%	8.3%	.2%	19.2%
Total		Count	229	182	1	412
		% within Annual Conference	55.6%	44.2%	.2%	100.0%
		% within Attended HIV/AIDS Presentation/Workshop in Local Church	100.0%	100.0%	100.0%	100.0%
		% of Total	55.6%	44.2%	.2%	100.0%

Chi-Square Tests

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	11.827(a)	8	.159
Likelihood Ratio	10.947	8	.205
Linear-by-Linear Association	3.910	1	.048
N of Valid Cases	412		

a 5 cells (33.3%) have expected count less than 5. The minimum expected count is .13.

Annual Conference * Attended HIV/AIDS Presentation/Workshop in District Conference

Crosstab

			Attended HIV/AIDS Presentation/Workshop in District Conference		Total
			Yes	No	Yes
Annual Conference	Baltimore	Count	23	21	44
		% within Annual Conference	52.3%	47.7%	100.0%
		% within Attended HIV/AIDS Presentation/Workshop in District Conference	15.1%	9.7%	12.0%
		% of Total	6.3%	5.7%	12.0%
	Washington	Count	42	64	106
		% within Annual Conference	39.6%	60.4%	100.0%
		% within Attended HIV/AIDS Presentation/Workshop in District Conference	27.6%	29.6%	28.8%
		% of Total	11.4%	17.4%	28.8%
	Virginia	Count	27	34	61
		% within Annual Conference	44.3%	55.7%	100.0%
		% within Attended HIV/AIDS Presentation/Workshop in District Conference	17.8%	15.7%	16.6%
		% of Total	7.3%	9.2%	16.6%
	North Carolina	Count	32	52	84
		% within Annual Conference	38.1%	61.9%	100.0%
		% within Attended HIV/AIDS Presentation/Workshop in District Conference	21.1%	24.1%	22.8%
		% of Total	8.7%	14.1%	22.8%
	Western North Carolina	Count	28	45	73
		% within Annual Conference	38.4%	61.6%	100.0%
		% within Attended HIV/AIDS Presentation/Workshop in District Conference	18.4%	20.8%	19.8%
		% of Total	7.6%	12.2%	19.8%
Total		Count	152	216	368
		% within Annual Conference	41.3%	58.7%	100.0%
		% within Attended HIV/AIDS Presentation/Workshop in District Conference	100.0%	100.0%	100.0%
		% of Total	41.3%	58.7%	100.0%

Chi-Square Tests

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	3.146(a)	4	.534
Likelihood Ratio	3.112	4	.539
Linear-by-Linear Association	1.390	1	.238
N of Valid Cases	368		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 18.17.

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Crosstabs

Notes

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Comments		
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	Cases Used	Statistics for each table are based on all the cases with valid data in the specified range(s) for all variables in each table.
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Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Annual Conference * Have Ever Attended a HIV/AIDS Presentation/Workshop	406	86.2%	65	13.8%	471	100.0%
Annual Conference * Ever Reviewed Pamphlets on HIV/AIDS	399	84.7%	72	15.3%	471	100.0%
Annual Conference * Ever Reviewed Fact Sheets on HIV/AIDS	265	56.3%	206	43.7%	471	100.0%
Annual Conference * Ever Reviewed Brochures on HIV/AIDS	329	69.9%	142	30.1%	471	100.0%
Annual Conference * Ever Reviewed Videos on HIV/AIDS	151	32.1%	320	67.9%	471	100.0%
Annual Conference * Likelihood to Support church-based HIV/AIDS Awareness Southern African Project	449	95.3%	22	4.7%	471	100.0%
Annual Conference * Past Year You or Any Other Clergy Discussed HIV/AIDS with the Congregation	444	94.3%	27	5.7%	471	100.0%
Annual Conference * HIV/AIDS transmitted by Kissing	100	21.2%	371	78.8%	471	100.0%
Annual Conference * HIV/AIDS transmitted by Sexual Contact	442	93.8%	29	6.2%	471	100.0%
Annual Conference * HIV/AIDS transmitted by IV Needle Sharing	437	92.8%	34	7.2%	471	100.0%
Annual Conference * HIV/AIDS transmitted by Blood Transfusions	438	93.0%	33	7.0%	471	100.0%
Annual Conference * HIV/AIDS transmitted by Toilet	28	5.9%	443	94.1%	471	100.0%

Annual Conference * Have Ever Attended a HIV/AIDS Presentation/Workshop

Crosstab

			Have Ever Attended a HIV/AIDS Presentation/Workshop		Total
			Yes	No	Yes
Annual Conference	Baltimore	Count	43	14	57
		% within Annual Conference	75.4%	24.6%	100.0%
		% within Have Ever Attended a HIV/AIDS Presentation/Workshop	15.1%	11.5%	14.0%
		% of Total	10.6%	3.4%	14.0%
	Washington	Count	81	39	120
		% within Annual Conference	67.5%	32.5%	100.0%
		% within Have Ever Attended a HIV/AIDS Presentation/Workshop	28.5%	32.0%	29.6%
		% of Total	20.0%	9.6%	29.6%
	Virginia	Count	50	17	67
		% within Annual Conference	74.6%	25.4%	100.0%
		% within Have Ever Attended a HIV/AIDS Presentation/Workshop	17.6%	13.9%	16.5%
		% of Total	12.3%	4.2%	16.5%
	North Carolina	Count	52	37	89
		% within Annual Conference	58.4%	41.6%	100.0%
		% within Have Ever Attended a HIV/AIDS Presentation/Workshop	18.3%	30.3%	21.9%
		% of Total	12.8%	9.1%	21.9%
	Western North Carolina	Count	58	15	73
		% within Annual Conference	79.5%	20.5%	100.0%
		% within Have Ever Attended a HIV/AIDS Presentation/Workshop	20.4%	12.3%	18.0%
		% of Total	14.3%	3.7%	18.0%
Total		Count	284	122	406
		% within Annual Conference	70.0%	30.0%	100.0%
		% within Have Ever Attended a HIV/AIDS Presentation/Workshop	100.0%	100.0%	100.0%
		% of Total	70.0%	30.0%	100.0%

Chi-Square Tests

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	10.615(a)	4	.031
Likelihood Ratio	10.578	4	.032
Linear-by-Linear Association	.001	1	.981
N of Valid Cases	406		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 17.13.

Annual Conference * Ever Reviewed Pamphlets on HIV/AIDS

Crosstab

			Ever Reviewed Pamphlets on HIV/AIDS	Total
			Yes	Yes
Annual Conference	Baltimore	Count	54	54
		% within Annual Conference	100.0%	100.0%
		% within Ever Reviewed Pamphlets on HIV/AIDS	13.5%	13.5%
		% of Total	13.5%	13.5%
	Washington	Count	120	120
		% within Annual Conference	100.0%	100.0%
		% within Ever Reviewed Pamphlets on HIV/AIDS	30.1%	30.1%
		% of Total	30.1%	30.1%
	Virginia	Count	65	65
		% within Annual Conference	100.0%	100.0%
		% within Ever Reviewed Pamphlets on HIV/AIDS	16.3%	16.3%
		% of Total	16.3%	16.3%
	North Carolina	Count	86	86
		% within Annual Conference	100.0%	100.0%
		% within Ever Reviewed Pamphlets on HIV/AIDS	21.6%	21.6%
		% of Total	21.6%	21.6%
	Western North Carolina	Count	74	74
		% within Annual Conference	100.0%	100.0%
		% within Ever Reviewed Pamphlets on HIV/AIDS	18.5%	18.5%
		% of Total	18.5%	18.5%
Total		Count	399	399
		% within Annual Conference	100.0%	100.0%
		% within Ever Reviewed Pamphlets on HIV/AIDS	100.0%	100.0%
		% of Total	100.0%	100.0%

Chi-Square Tests

	Value
Pearson Chi-Square	.(a)
N of Valid Cases	399

a No statistics are computed because Ever Reviewed Pamphlets on HIV/AIDS is a constant.

Annual Conference * Ever Reviewed Fact Sheets on HIV/AIDS

Crosstab

			Ever Reviewed Fact Sheets on HIV/AIDS		Total
			Yes	9.00	Yes
Annual Conference	Baltimore	Count	37	0	37
		% within Annual Conference	100.0%	.0%	100.0%
		% within Ever Reviewed Fact Sheets on HIV/AIDS	14.1%	.0%	14.0%
		% of Total	14.0%	.0%	14.0%
	Washington	Count	87	0	87
		% within Annual Conference	100.0%	.0%	100.0%
		% within Ever Reviewed Fact Sheets on HIV/AIDS	33.1%	.0%	32.8%
		% of Total	32.8%	.0%	32.8%
	Virginia	Count	44	0	44
		% within Annual Conference	100.0%	.0%	100.0%
		% within Ever Reviewed Fact Sheets on HIV/AIDS	16.7%	.0%	16.6%
		% of Total	16.6%	.0%	16.6%
	North Carolina	Count	47	1	48
		% within Annual Conference	97.9%	2.1%	100.0%
		% within Ever Reviewed Fact Sheets on HIV/AIDS	17.9%	50.0%	18.1%
		% of Total	17.7%	.4%	18.1%
	Western North Carolina	Count	48	1	49
		% within Annual Conference	98.0%	2.0%	100.0%
		% within Ever Reviewed Fact Sheets on HIV/AIDS	18.3%	50.0%	18.5%
		% of Total	18.1%	.4%	18.5%
Total		Count	263	2	265
		% within Annual Conference	99.2%	.8%	100.0%
		% within Ever Reviewed Fact Sheets on HIV/AIDS	100.0%	100.0%	100.0%
		% of Total	99.2%	.8%	100.0%

Chi-Square Tests

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	3.491(a)	4	.479
Likelihood Ratio	4.047	4	.400
Linear-by-Linear Association	2.696	1	.101
N of Valid Cases	265		

a 5 cells (50.0%) have expected count less than 5. The minimum expected count is .28.

Annual Conference * Ever Reviewed Brochures on HIV/AIDS

Crosstab

			Ever Reviewed Brochures on HIV/AIDS	Total
			Yes	Yes
Annual Conference	**Baltimore**	Count	45	45
		% within Annual Conference	100.0%	100.0%
		% within Ever Reviewed Brochures on HIV/AIDS	13.7%	13.7%
		% of Total	13.7%	13.7%
	Washington	Count	102	102
		% within Annual Conference	100.0%	100.0%
		% within Ever Reviewed Brochures on HIV/AIDS	31.0%	31.0%
		% of Total	31.0%	31.0%
	Virginia	Count	61	61
		% within Annual Conference	100.0%	100.0%
		% within Ever Reviewed Brochures on HIV/AIDS	18.5%	18.5%
		% of Total	18.5%	18.5%
	North Carolina	Count	62	62
		% within Annual Conference	100.0%	100.0%
		% within Ever Reviewed Brochures on HIV/AIDS	18.8%	18.8%
		% of Total	18.8%	18.8%
	Western North Carolina	Count	59	59
		% within Annual Conference	100.0%	100.0%
		% within Ever Reviewed Brochures on HIV/AIDS	17.9%	17.9%
		% of Total	17.9%	17.9%
Total		Count	329	329
		% within Annual Conference	100.0%	100.0%
		% within Ever Reviewed Brochures on HIV/AIDS	100.0%	100.0%
		% of Total	100.0%	100.0%

Chi-Square Tests

	Value
Pearson Chi-Square	.(a)
N of Valid Cases	329

a No statistics are computed because Ever Reviewed Brochures on HIV/AIDS is a constant.

Annual Conference * Ever Reviewed Videos on HIV/AIDS

Crosstab

			Ever Reviewed Videos on HIV/AIDS		Total
			Yes	9.00	Yes
Annual Conference	**Baltimore**	Count	33	0	33
		% within Annual Conference	100.0%	.0%	100.0%
		% within Ever Reviewed Videos on HIV/AIDS	22.1%	.0%	21.9%
		% of Total	21.9%	.0%	21.9%
	Washington	Count	44	0	44
		% within Annual Conference	100.0%	.0%	100.0%
		% within Ever Reviewed Videos on HIV/AIDS	29.5%	.0%	29.1%
		% of Total	29.1%	.0%	29.1%
	Virginia	Count	22	0	22
		% within Annual Conference	100.0%	.0%	100.0%
		% within Ever Reviewed Videos on HIV/AIDS	14.8%	.0%	14.6%
		% of Total	14.6%	.0%	14.6%
	North Carolina	Count	26	1	27
		% within Annual Conference	96.3%	3.7%	100.0%
		% within Ever Reviewed Videos on HIV/AIDS	17.4%	50.0%	17.9%
		% of Total	17.2%	.7%	17.9%
	Western North Carolina	Count	24	1	25
		% within Annual Conference	96.0%	4.0%	100.0%
		% within Ever Reviewed Videos on HIV/AIDS	16.1%	50.0%	16.6%
		% of Total	15.9%	.7%	16.6%
Total		Count	149	2	151
		% within Annual Conference	98.7%	1.3%	100.0%
		% within Ever Reviewed Videos on HIV/AIDS	100.0%	100.0%	100.0%
		% of Total	98.7%	1.3%	100.0%

Chi-Square Tests

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	3.868(a)	4	.424
Likelihood Ratio	4.319	4	.365
Linear-by-Linear Association	3.036	1	.081
N of Valid Cases	151		

a 5 cells (50.0%) have expected count less than 5. The minimum expected count is .29.

Annual Conference * Likelihood to Support Church-based HIV/AIDS Awareness Southern African Project

Crosstab

			Likelihood to Support Church-based HIV/AIDS Awareness Southern African Project					Total
			Very Likely	Some what Likely	Unlikely	Not At All	Unsure	Very Likely
Annual Conference	Baltimore	Count	42	13	2	0	3	60
		% within Annual Conference	70.0%	21.7%	3.3%	.0%	5.0%	100.0%
		% within Likelihood to Support church-based HIV/AIDS Awareness Southern African Project	16.5%	9.1%	8.0%	.0%	13.0%	13.4%
		% of Total	9.4%	2.9%	.4%	.0%	.7%	13.4%
	Washington	Count	73	44	7	1	7	132
		% within Annual Conference	55.3%	33.3%	5.3%	.8%	5.3%	100.0%
		% within Likelihood to Support church-based HIV/AIDS Awareness Southern African Project	28.7%	30.8%	28.0%	25.0%	30.4%	29.4%
		% of Total	16.3%	9.8%	1.6%	.2%	1.6%	29.4%
	Virginia	Count	46	25	6	0	2	79
		% within Annual Conference	58.2%	31.6%	7.6%	.0%	2.5%	100.0%
		% within Likelihood to Support church-based HIV/AIDS Awareness Southern African Project	18.1%	17.5%	24.0%	.0%	8.7%	
		% of Total	10.2%	5.6%	1.3%	.0%	.4%	17.6%

			Likelihood to Support Church-based HIV/AIDS Awareness Southern African Project *(Continued)*					Total
			Very Likely	Some what Likely	Unlik ely	Not At All	U n s u r e	Very Likely
	North Carolina	Count	56	25	7	3	5	96
		% within Annual Conference	58.3%	26.0%	7.3%	3.1%	5.2%	1 0 0 . 0 %
		% within Likelihood to Support church-based HIV/AIDS Awareness Southern African Project	22.0%	17.5%	28.0%	75.0%	21.7%	21.4%
		% of Total	12.5%	5.6%	1.6%	.7%	1.1%	21.4%
	Western North Carolina	Count	37	36	3	0	6	82
		% within Annual Conference	45.1%	43.9%	3.7%	.0%	7.3%	100.0%
		% within Likelihood to Support church-based HIV/AIDS Awareness Southern African Project	14.6%	25.2%	12.0%	.0%	26.1%	18.3%
		% of Total	8.2%	8.0%	.7%	.0%	1.3%	18.3%
Total		Count	254	143	25	4	23	449
		% within Annual Conference	56.6%	31.8%	5.6%	.9%	5.1%	100.0%
		% within Likelihood to Support church-based HIV/AIDS Awareness Southern African Project	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0%
		% of Total	56.6%	31.8%	5.6%	.9%	5.1%	100.0%

Chi-Square Tests

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	22.123(a)	16	.139
Likelihood Ratio	22.087	16	.140
Linear-by-Linear Association	2.844	1	.092
N of Valid Cases	449		

a 12 cells (48.0%) have expected count less than 5. The minimum expected count is .53.

Annual Conference * Past Year You or Any Other Clergy Discussed HIV/AIDS with the Congregation

Crosstab

			Past Year You or Any Other Clergy Discussed HIV/AIDS with the Congregation				Total
			Very Likely	Somewhat Likely	Unlikely	Unsure	Very Likely
Annual Conference	Baltimore	Count	30	24	5	2	61
		% within Annual Conference	49.2%	39.3%	8.2%	3.3%	100.0%
		% within Past Year You or Any Other Clergy Discussed HIV/AIDS with the Congregation	16.8%	11.1%	10.6%	100.0%	13.7%
		% of Total	6.8%	5.4%	1.1%	.5%	13.7%
	Washington	Count	62	55	12	0	129
		% within Annual Conference	48.1%	42.6%	9.3%	.0%	100.0%
		% within Past Year You or Any Other Clergy Discussed HIV/AIDS with the Congregation	34.6%	25.5%	25.5%	.0%	29.1%
		% of Total	14.0%	12.4%	2.7%	.0%	29.1%
	Virginia	Count	23	40	10	0	73
		% within Annual Conference	31.5%	54.8%	13.7%	.0%	100.0%
		% within Past Year You or Any Other Clergy Discussed HIV/AIDS with the Congregation	12.8%	18.5%	21.3%	.0%	16.4%
		% of Total	5.2%	9.0%	2.3%	.0%	16.4%

			Past Year You or Any Other Clergy Discussed HIV/AIDS with the Congregation *(Continued)*				Total
			Very Likely	Somewhat Likely	Unlikely	Unsure	Very Likely
	North Carolina	Count	34	51	14	0	99
		% within Annual Conference	34.3%	51.5%	14.1%	.0%	100.0%
		% within Past Year You or Any Other Clergy Discussed HIV/AIDS with the Congregation	19.0%	23.6%	29.8%	.0%	22.3%
		% of Total	7.7%	11.5%	3.2%	.0%	22.3%
	Western North Carolina	Count	30	46	6	0	82
		% within Annual Conference	36.6%	56.1%	7.3%	.0%	100.0%
		% within Past Year You or Any Other Clergy Discussed HIV/AIDS with the Congregation	16.8%	21.3%	12.8%	.0%	18.5%
		% of Total	6.8%	10.4%	1.4%	.0%	18.5%
Total		Count	179	216	47	2	444
		% within Annual Conference	40.3%	48.6%	10.6%	.5%	100.0%
		% within Past Year You or Any Other Clergy Discussed HIV/AIDS with the Congregation	100.0%	100.0%	100.0%	100.0%	100.0%
		% of Total	40.3%	48.6%	10.6%	.5%	100.0%

Chi-Square Tests

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	25.152(a)	12	.014
Likelihood Ratio	20.530	12	.058
Linear-by-Linear Association	1.457	1	.227
N of Valid Cases	444		

a 5 cells (25.0%) have expected count less than 5. The minimum expected count is .27.

Annual Conference * HIV/AIDS transmitted by Kissing

Crosstab

			HIV/AIDS Transmitted by Kissing	Total
			Yes	Yes
Annual Conference	Baltimore	Count	14	14
		% within Annual Conference	100.0%	100.0%
		% within HIV/AIDS transmitted by Kissing	14.0%	14.0%
		% of Total	14.0%	14.0%
	Washington	Count	36	36
		% within Annual Conference	100.0%	100.0%
		% within HIV/AIDS transmitted by Kissing	36.0%	36.0%
		% of Total	36.0%	36.0%
	Virginia	Count	14	14
		% within Annual Conference	100.0%	100.0%
		% within HIV/AIDS transmitted by Kissing	14.0%	14.0%
		% of Total	14.0%	14.0%
	North Carolina	Count	20	20
		% within Annual Conference	100.0%	100.0%
		% within HIV/AIDS transmitted by Kissing	20.0%	20.0%
		% of Total	20.0%	20.0%
	Western North Carolina	Count	16	16
		% within Annual Conference	100.0%	100.0%
		% within HIV/AIDS transmitted by Kissing	16.0%	16.0%
		% of Total	16.0%	16.0%
Total		Count	100	100
		% within Annual Conference	100.0%	100.0%
		% within HIV/AIDS transmitted by Kissing	100.0%	100.0%
		% of Total	100.0%	100.0%

Chi-Square Tests

	Value
Pearson Chi-Square	.(a)
N of Valid Cases	100

a No statistics are computed because HIV/AIDS transmitted by Kissing is a constant.

Annual Conference * HIV/AIDS Transmitted by Sexual Contact

Crosstab

			HIV/AIDS Transmitted by Sexual Contact	Total
			Yes	Yes
Annual Conference	Baltimore	Count	59	59
		% within Annual Conference	100.0%	100.0%
		% within HIV/AIDS Transmitted by Sexual Contact	13.3%	13.3%
		% of Total	13.3%	13.3%
	Washington	Count	131	131
		% within Annual Conference	100.0%	100.0%
		% within HIV/AIDS Transmitted by Sexual Contact	29.6%	29.6%
		% of Total	29.6%	29.6%
	Virginia	Count	73	73
		% within Annual Conference	100.0%	100.0%
		% within HIV/AIDS Transmitted by Sexual Contact	16.5%	16.5%
		% of Total	16.5%	16.5%
	North Carolina	Count	96	96
		% within Annual Conference	100.0%	100.0%
		% within HIV/AIDS Transmitted by Sexual Contact	21.7%	21.7%
		% of Total	21.7%	21.7%
	Western North Carolina	Count	83	83
		% within Annual Conference	100.0%	100.0%
		% within HIV/AIDS Transmitted by Sexual Contact	18.8%	18.8%
		% of Total	18.8%	18.8%
Total		Count	442	442
		% within Annual Conference	100.0%	100.0%
		% within HIV/AIDS Transmitted by Sexual Contact	100.0%	100.0%
		% of Total	100.0%	100.0%

Chi-Square Tests

	Value
Pearson Chi-Square	.(a)
N of Valid Cases	442

a No statistics are computed because HIV/AIDS transmitted by Sexual Contact is a constant.

Annual Conference * HIV/AIDS Transmitted by IV Needle Sharing

Crosstab

			HIV/AIDS Transmitted by IV Needle Sharing	Total
			Yes	Yes
Annual Conference	Baltimore	Count	59	59
		% within Annual Conference	100.0%	100.0%
		% within HIV/AIDS Transmitted by IV Needle Sharing	13.5%	13.5%
		% of Total	13.5%	13.5%
	Washington	Count	130	130
		% within Annual Conference	100.0%	100.0%
		% within HIV/AIDS Transmitted by IV Needle Sharing	29.7%	29.7%
		% of Total	29.7%	29.7%
	Virginia	Count	70	70
		% within Annual Conference	100.0%	100.0%
		% within HIV/AIDS Transmitted by IV Needle Sharing	16.0%	16.0%
		% of Total	16.0%	16.0%
	North Carolina	Count	96	96
		% within Annual Conference	100.0%	100.0%
		% within HIV/AIDS Transmitted by IV Needle Sharing	22.0%	22.0%
		% of Total	22.0%	22.0%
	Western North Carolina	Count	82	82
		% within Annual Conference	100.0%	100.0%
		% within HIV/AIDS Transmitted by IV Needle Sharing	18.8%	18.8%
		% of Total	18.8%	18.8%
Total		Count	437	437
		% within Annual Conference	100.0%	100.0%
		% within HIV/AIDS Transmitted by IV Needle Sharing	100.0%	100.0%
		% of Total	100.0%	100.0%

Chi-Square Tests

	Value
Pearson Chi-Square	.(a)
N of Valid Cases	437

a No statistics are computed because HIV/AIDS transmitted by IV Needle Sharing is a constant.

Annual Conference * HIV/AIDS Transmitted by Blood Transfusions

Crosstab

			HIV/AIDS Transmitted by Blood Transfusions	Total
			Yes	Yes
Annual Conference	Baltimore	Count	59	59
		% within Annual Conference	100.0%	100.0%
		% within HIV/AIDS Transmitted by Blood Transfusions	13.5%	13.5%
		% of Total	13.5%	13.5%
	Washington	Count	129	129
		% within Annual Conference	100.0%	100.0%
		% within HIV/AIDS Transmitted by Blood Transfusions	29.5%	29.5%
		% of Total	29.5%	29.5%
	Virginia	Count	71	71
		% within Annual Conference	100.0%	100.0%
		% within HIV/AIDS Transmitted by Blood Transfusions	16.2%	16.2%
		% of Total	16.2%	16.2%
	North Carolina	Count	96	96
		% within Annual Conference	100.0%	100.0%
		% within HIV/AIDS Transmitted by Blood Transfusions	21.9%	21.9%
		% of Total	21.9%	21.9%
	Western North Carolina	Count	83	83
		% within Annual Conference	100.0%	100.0%
		% within HIV/AIDS Transmitted by Blood Transfusions	18.9%	18.9%
		% of Total	18.9%	18.9%
Total		Count	438	438
		% within Annual Conference	100.0%	100.0%
		% within HIV/AIDS Transmitted by Blood Transfusions	100.0%	100.0%
		% of Total	100.0%	100.0%

Chi-Square Tests

	Value
Pearson Chi-Square	.(a)
N of Valid Cases	438

a No statistics are computed because HIV/AIDS transmitted by Blood Transfusions is a constant.

Annual Conference * HIV/AIDS Transmitted by Toilet

Crosstab

			HIV/AIDS Transmitted by Toilet	Total
			Yes	Yes
Annual Conference	Baltimore	Count	2	2
		% within Annual Conference	100.0%	100.0%
		% within HIV/AIDS transmitted by Toilet	7.1%	7.1%
		% of Total	7.1%	7.1%
	Washington	Count	12	12
		% within Annual Conference	100.0%	100.0%
		% within HIV/AIDS transmitted by Toilet	42.9%	42.9%
		% of Total	42.9%	42.9%
	Virginia	Count	2	2
		% within Annual Conference	100.0%	100.0%
		% within HIV/AIDS transmitted by Toilet	7.1%	7.1%
		% of Total	7.1%	7.1%
	North Carolina	Count	6	6
		% within Annual Conference	100.0%	100.0%
		% within HIV/AIDS transmitted by Toilet	21.4%	21.4%
		% of Total	21.4%	21.4%
	Western North Carolina	Count	6	6
		% within Annual Conference	100.0%	100.0%
		% within HIV/AIDS transmitted by Toilet	21.4%	21.4%
		% of Total	21.4%	21.4%
Total		Count	28	28
		% within Annual Conference	100.0%	100.0%
		% within HIV/AIDS transmitted by Toilet	100.0%	100.0%
		% of Total	100.0%	100.0%

Chi-Square Tests

	Value
Pearson Chi-Square	.(a)
N of Valid Cases	28

a No statistics are computed because HIV/AIDS transmitted by Toilet is a constant.

APPENDIX F

SELECTED QUALITATIVE RESULTS

Tape # 2
Date: 2/26/2004
Facilitator: Reverend Cassandra Sparrow
Presiding Elder/Baltimore

Facilitator: Now the tape is on, do you mind if this interview is taped?

Participant: No

F: Ok, thank you. The responses will be used to assist with understanding data on an Annual Conference Level. Please note that this data is being collected as a part of a Doctor of Ministry project with United Theological Seminary as well as HIV/AIDS project activities of Pilgrim Community Outreach Corporation. Do you have any objections to this interview transcript being used for these purposes?

P: None

F: Ok, thank you and for more information you can contact Reverend Cassandra Sparrow, [that] is me, and I can give you the number if you need it and that's XXX-XXX-XXXX. There are seven questions in all and then some background questions. Do you recall the HIV/AIDS survey disseminated at the 2003 Midyear conference in Raleigh, NC?

P: Yes, I was there I remember.

F: Did you complete the survey?

P: No, I didn't

F: Preliminary assessment shows that approximately 63 surveys were received form members of the Baltimore Annual Conference. On a scale of one to five, where one is low and five is high how would you rate the overall readiness of the churches on your district to address HIV/AIDS?

P: I would say, I would go in between - three.

F: Can you explain your response?

P: Yes, because truthfully I don't see too many conversations pertaining to AIDS and I'm a little disturbed about it on the district.

F: Ok, you're disturbed about....

P: about how they responding to AIDS, the seriousness of AIDS, I don't see too many pastors ....they seem lackadaisical they don't seem like they're with it too much.

F: Are you aware of any other churches or agencies in your district engaged in any efforts to address HIV/AIDS?

P: No

F: That last question couldn't involve any agencies outside of the church is that still correct?

P: Yes

F: Has there ever been a health presentation at a district conference under your leadership?

P: Oh, yes.

F: How long ago?

P: Two years ago, that's the latest I had health benefit that Reverend XXXXXXXXX XXXXXXX, who is a registered nurse and Reverend XXXXXX XXXXX, they did a health thing at the district conference a couple years ago. I would say Reverend XXXXXXX did one just last year.

F: Last year, so within the last two years you've had a couple?

P: Yes

F: Now, you said the other person was Reverend XXXXXXX?

P: Yes, XXXXXXX XXXXX

F: Was either of those health presentations related to HIV/AIDS?

P: No, they weren't.

F: Next question, what do you think the major opportunities are to implementing HIV/AIDS awareness project in your district conference?

P: The opportunity in my district I would say most the major part of my district is rural setting. The opportunity there for someone to come in and do an AIDS project would be great because of the setting there, it's not like the city environment and so they don't have box minded to the nature of things in the rural as they do in the city so I think it's a great opportunity there.

F: Ok, any others?

P: Not really.

F: Ok, what about challenges, what do you think the major challenges are to HIV/AIDS awareness project in your district conference?

P: That's a good question, at this particular moment the challenge there would be to [have], someone to inspire or to boast or to edge, not just a pastor but the people into taking more consideration into the AIDS program, about AIDS, they need to be boosted. I don't know Cassandra, if you will allow me to say that.

F: Oh, sure.

P: It just seems that folk are taking AIDS as something just passing by, as just another name they don't seem to be wrapped up in this thing like maybe cancer or gonorrhea or syphilis even. They don't seem to be taking AIDS as if it were AIDS or HIV and then gone, you understand what I'm saying?

F: Yes.

P: It's not an interest there, in the community.

F: How open are you in your position as presiding elder to help raise awareness on HIV/AIDS?

P: Well, I try to do as much in my own little way, as much as I can about it and talk about it and try to inspire and instill in them that it is something that's alive and they need to be more concerned about it, even the young people. Particularly the young people on the sexuality part of it, instilling in them that it's not just about sex you need something more then just to be thinking about the sexual part. You understand what I'm saying?

F: Yes.

P: Well, I try but I'm a little concerned because I see so many of our little girls that have become pregnant in the last couple years that I had big hopes for and seeing them dropping out of schools and everything.

F: Ok, what could be done to assist you?

[Confidential statements made]

F: Either way, are there any concerns or conditions that might hinder your involvement?

P: Well, yes if my health holds up physically I feel, but see when your fight is not like it used to be. Not as sharp, that' s a great hindering to me so that' s one of the things that beginning to bother me, I can see but it' s not as sharp as it used to be.

F: Now you mentioned retirement, do you see that as a condition that might hinder your involvement?

P: In a sorts, yes. As far as being in group settings, meeting large number of persons. I won' t be too involved in... because I won' t be able to get around as much as I used to.

F: Ok, well I would say that your wisdom and your insight will still be very important to all of us.

P: Well I lend my little, what I have when I' m around and I even tell the district that, yeah I' ll come around when I have the opportunity or you have a program you want me to run somewhere I can try to make myself available but just let me know in time to prepare myself. You know what I' m saying?

F: Well, thank you. Those are the seven main questions there are a few additional background questions if you wouldn' t mind answering and then we' ll be concluded. Your length of time as a presiding elder at your current district?

Confidential data begins – Selected responses provided.

F: How would you classify all of the churches in your district; urban, suburban or rural?

P: 3/4 of the churches in the Baltimore conference are rural churches. There are about

F: What about in the Eastern district?

P: Oh, that' s my district my first five churches are urban, the rest are rural. I have thirty churches on my district.

F: You have thirty churches in your district?

P: When you have cities like Elkton, Havre De Grace they are cities but not like urban cities like Baltimore.

[Confidential Data Shared]

F: Tremendous legacy. Well, presiding elder, I appreciate you taking this time and sharing this with me even as you have a busy schedule there. [Confidential Data Shared]

Tape #1
Date: 2/24/2004
Facilitator: Reverend Cassandra Sparrow
Presiding Elder/Washington

Facilitator: Do you mind if this interview is taped?

Participant: No

F: Ok, thank you. The responses will be used to assist with understanding data on an annual conference level. Please note that this data is being collected as part of a Doctor of Ministry project with United Theological Seminary as well as HIV/AIDS project activities of Pilgrim Community Outreach Corporation. Do you have any objection to this interview transcript being used for these purposes?

P: No.

F: Ok, for more information you can contact Rev. Cassandra Sparrow, which is me at XXX-XXX-XXXX. I can certainly get that to you in another form. Ok?

P: Alright.

F: Are you ready to begin the questions?

P: Yes.

F: Do you recall the HIV/AIDS survey disseminated at the 2003 Midyear conference in Raleigh, NC?

P: No, I don't.

F: Ok, the next question is did you complete the survey?

P: You said 2003?

F: Yes, the one that just passed.

P: Oh, yes. I'm sorry.

F: It was a yellow one-pager. You might have gotten it at the RED Board meeting.

P: I think I filled it out and gave it back to you. I don't think I remember any specifics on it.

F: That's ok, just if you remember that there was such a survey.

P: Yes, I remember,

F: Ok, and do you think you completed it?

P: Yes.

F: Ok, preliminary assessment shows that approximately 133 surveys were received from members of the Washington Annual Conference at that session on a scale of one to five, where one is low and five is high how would you rate the overall readiness of churches on your district to address HIV/AIDS?

P: I would say maybe two and a half. You said one to five?

F: Yes.

P: Yeah, I would say about half of that would be about 2.5, I would imagine.

F: Or three? Please explain your response.

P: I think so because mainly because of conversations with people I just don't find as many churches talking about that or doing anything programmatically to address the issue as I hear various reports from (inaudible) and other kinds of social outreach ministries in the church I hear nothing about anything their doing about HIV/AIDS, virtually nothing.

F: Are you aware of any other churches or agencies located in your district engaged in efforts to address HIV/AIDS?

P: Well at one point there was when I was in XXXXXXX still in the Potomac District there was a black ministers association. I can't recall the specific name at this point, who was concerned and dealt with health related issues and would from time to time they would feature some of that in some of its program but that's all I know of at this point.

F: Ok, what about other agencies outside of the church?

P: Well, yes. I can't think of their names but there are some agencies outside of the church.

F: This is mainly to see if there are any that immediately come to mind that you are aware of. Has there ever been a health presentation at a district conference under your leadership?

P: Yes, there has been.

F: How long ago do you think?

P: It was maybe a year ago or so. Not this year but that would have been 2002

F: P: This was pretty much a fitness, health and fitness for the body if I recall. Do you recall what areas were addressed?

F: Has HIV/AIDS been addressed?

P: No, HIV/AIDS has never been specifically addressed. No

F: What do you think the major opportunities are to implementing HIV/AIDS awareness project in your district conference?

P: Well, I think, if I'm understanding the question correctly, I think the opportunities are great to do so. I think it's a matter of the program committee identifying this as a

priority, and with my participation and then going forth to identifying peoples to do it. So, I think the opportunities are great.

F: What do you think the challenges are?

P: Well, I think the challenges would be, well I don't think the challenge would be towards getting a program in place, the challenges may be toward getting churches to hear and to get to move toward putting something in place for the individual congregations.

F: Ok, are there any others?

P: No, none that I can think of right now

F: How open are you in your position as presiding elder to help raise awareness on HIV/AIDS?

P: Very open, I would have no problem with it whatsoever in helping doing so.

F: Ok, what could assist you?

P: I guess identification of resources, and a resource person who would be available to conduct a session and do follow up with the various congregations, primarily a resource problem that I'm concerned with. That would be my issue.

F: In resources, what kinds of things specifically would you do?

P: Persons, number one and I (inaudible) and other contacts of ways to inform people.

F: Are there any concerns or conditions that might hinder your involvement?

P: No, none whatsoever. I can't conceive of anything at this point that would hinder my involvement at all.

F: What about the district as a whole?

P: I think it's just a matter of, well I know you can't dictate people to do something. All you can do is provide them the opportunity and exposure and people and individual pastors see it as a need and the respective community will follow up. I don't think that not having the in-depth knowledge of each respective church other than provide information and education and then hopefully someone will take it up and go with it.

F: Ok, well actually that is the (inaudible) questions. There are just a few background questions if you wouldn't mind answering those as well.

P: Go right ahead

Confidential data begins – Selected responses provided.

F: How would you classify most of the churches in your district, urban, suburban, or rural?

P: Urban

F: And the size, but you already said thirty-eight?

P: Yes, thirty-eight.

Confidential information shared.

F: Well that's all, thank you so much

P: I hope this goes well for you.

Tape #3

Date: 3/1/2004
Facilitator: Reverend Cassandra Sparrow
Presiding Elder/Virginia

Facilitator: Do you mind if this interview is taped?

Participant: No, I do not mind.

F: The responses will be used to assist with understanding data on an Annual Conference Level. Please note that this data is being collected as a part of a Doctor of Ministry project with United Theological Seminary as well as HIV/AIDS project activities of Pilgrim Community Outreach Corporation. Do you have any objection to this interview transcript being used for these purposes?

P: No, I do not.

F: If you need more information you can contact Reverend Cassandra Sparrow, which is me at XXX-XXX-XXXX. The first question, do you recall the HIV/AIDS survey disseminated at the 2003 Midyear conference in Raleigh, NC?

P: Yes, I do.

F: Did you complete the survey?

P: I did complete it.

F: Ok, preliminary assessment shows that approximately 80 surveys were received from members of the Virginia Annual Conference. On a scale of one to five, where one is low and five is high how would you rate the overall readiness of churches on your district to address HIV/AIDS?

P: I would rate a five, and the reason is we have had at least two sessions or two presentations in the past since I've been presiding elder, and interest seemed very high and people seemed very receptive. And they attended the sessions well.

F: Ok, wonderful. I will probably ask you later on in the interview, there'll be a few more questions related to that. The third question is are you aware of any other churches or agencies in your area engaged in efforts to address HIV/AIDS?

P: I don't know if there are any in my churches engaged presently, but I do know that there were two that had presentations.

F: Do you know which two?

P: Yes, St. John's Norfolk and Belle Haven, Second.

F: "The Belle Haven Second." Where is that located?

P: On the Eastern Shore of Virginia

F: Ok, what about any agencies?

P: Ok, not since I've been presiding elder an agency came in while I was pastor in this district, but not since I was presiding elder.

F: Well, is it still in existence?

P: Yes, it was the health department from Portsmouth…come over and do a workshop on AIDS and AIDS prevention while I was the pastor.

F: While you were the pastor at what church?

P: St John's, a church over there in Norfolk.

F: I just want to make sure I got all of your responses, so the St. John's in Norfolk and the Belle Haven Second on the Eastern Shore.

P: They are churches. The question is there weren't many churches or agencies in your district engaged in them, as I say I am not certain that they are presently engaged but in the past they have been. I do know they have had it since I have been

presiding elder, but I'm not sure which one or if they still have that program going on.

F: and the other agency would be the one when you were pastor and that was represented from a group in Portsmouth?

P: Yes.

F: Fourth question, has there ever been a health presentation at a district conference under your leadership?

P: Yes, we had two presentations, one in 2000 the other 2001. It was conducted by a RN who was working on her Masters and her name was [XXXX]. She was also a captain or a major in the medical core as a registered nurse with the US (inaudible) who was a member at AME & made two presentations on HIV/AIDS awareness and prevention. Also, a session on statistics (inaudible) affected carriers of this disease.

F: Now, the two presentations, one was in 2000 and the other in 2001?

P: Yes.

F: Were there any other health presentations that [were] not HIV that [were] conducted over that year?

P: No, let me see, we had a session on, a woman came in who was also in the ministry she was a minister she did something for us on organ donation.

F: How long ago was that?

F: 2002?

P: Yes, at the district conference. Let me say this, what I've been trying to do is to bring those things to our district that affects our people. For instance, we had a session on death and dying…can you hold for a minute.

F: Sure

P: Ok, what was I saying?

F: You were saying you had a session on preparation on death and dying…

P: Oh, yes we also had a minister who was also a funeral director who came and gave us a session on that because we feel like people just don't know what it's like or a spot where they can go and get a lot of things. [Tape becomes inaudible & muffled]

TAPE HAS ENDED – [Refer to handwritten notes.]

Tape #2
Dates: 2/25/2004
Facilitator: Reverend Cassandra Sparrow
Presiding Elder/Western North Carolina

Facilitator: .....if this interview is taped?

Participant: No I don't mind

F: Ok, thank you. The responses will be used to assist with understanding data on an Annual Conference Level. Please note that this data is being collected as part of a Doctor of Ministry project with United Theological Seminary as well as HIV/AIDS project activities of Pilgrim Community Outreach Corporation. Do you have any objection to this interview transcript being used for these purposes?

P: No

F: Ok, do you recall the HIV/AIDS Survey disseminated at the 2003 Midyear conference in Raleigh, NC?

P: No, I don't remember.

F: Ok, so you may not...let me give you a sense....it was a yellow survey, it was a while back, it was a one page. It was disseminated on a Saturday of that Midyear conference. Still don't recall?

P: No I don't. I've dealt with so many of them through so many different agents. I don't remember that one.

F: Ok, that's ok. This is all pertaining to internal stuff that happened within the AME church, that assessment that we did on that Saturday of the Midyear we received 80 surveys from Virginia. I'm sorry you're not from....

P: Western North Carolina

F: Western North Carolina, I′ m sorry we did 86 surveys from the Western North Carolina conference that were returned. Now as a general question on a scale of one to five, where one is low and five is high how would you rate the overall readiness of churches on your district to address HIV/AIDS?

P: Ummm, three.

F: Three, and why do you say three?

P: because there is not enough information that has been, there is a lot of information out there, but not enough has actually brought into the church to give the church the kind of stance it ought to take.

F: Ok, Are you aware of any other churches or agencies in your district engaged in efforts to address HIV/AIDS?

P: Yes, we have in the different...in the western end of my district over in the foothills around Loginton [spelling?], Hickory, Lenoir. There′ s an agency that has penetrated the churches and is doing quite a good job.

F: Do you remember the name of that agency?

P: That agency, I′ m trying to think the name up....let me get to my desk....[pause]....can′ t put my hand on it (inaudible)

F: It is, you said, in the western end and its…

P: Here it is. It is A Leadership Foothills Allya Alliance Inc. (?)

F: Do you have a contact for them?

P: Yes, XXXX XXXXX [Name Given].

F: I′ m not familiar with that agency, do you have a number?

P: Yes, XXX-XXX-XXXX and in fact a person from the agency is going to do a workshop at my district conference on the 14th of next month.

F: Ok, well that's going to answer another question I have in a few minutes. That's good. Now what about any churches? Do you know of any churches on your district that are currently involved with any HIV/AIDS work?

P: No, not formally, but this leadership area alliance is penetrating the churches in that area and using the church as part of its sponsorship.

F: Has there ever been a health presentation at your district conference under your leadership?

P: No.

F: What do you think the major opportunities are to implementing HIV/AIDS awareness project in your district?

P: The opportunities are there, and I think it's the consciousness of the people at this juncture. I think they are ready to do something about it as much as we can.

F: And you said you had something scheduled?

P: Yes, for the 15th of next month at a workshop some people from the agency will be there.

F: And this is the first time that...

P: They sponsor a black church week of prayer for the healing of the AIDS and that is one of the activities within the church that this agency encourages.

F: Ok, I'm familiar with that. Now what do you think some of the challenges are to raising HIV/AIDS awareness or doing an HIV/AIDS awareness project in your

district?

P: Well, let me see, the challenges are that we just have not given ourselves a true and concerted program of helping in this area. Now one of the things is we are hopeful that through working through this agency, pastors can be better prepared to deal with persons coming to him or her with AIDS or with family members who have AIDS. As a referral agency, you know, a person comes to him and says, "Pastor, I' ve got AIDS. I' ve discovered that I' m HIV positive." What does a pastor do other than pray? There is something else he or she ought to be able to do, to send them to somebody who can give them some concrete help and that is what the church is lacking nowadays and what we hope on becoming familiar with and experts at.

F: Ok, are you, and just going through the questions again, are you in your position as an give them some concrete help and that is what the church is lacking nowadays presiding elder to help raise awareness on HIV/AIDS?

P: Wide open.

F: And what could be done to assist you specifically?

P: Well, education primarily. I have something that I would like to fax to you.

F: Sure.

P: It' s AIDS Leadership Foothills Allya Alliance current fact sheet 2004. (Inaudible)

F: Great, that' s great. I would love to take a look at that.

P: If you would give me a fax number as soon as we get finished I will go ahead and put it on the wire for you.

F: You want me to give it to you now?

P: Yes

F: XXX-XXX-XXXX

P: I will fax you two or three sheets that might be of some use to you.

F: In terms of your role as presiding elder, are there any concerns or conditions that might hinder your involvement.

P: No, I don't see anything that would hinder me from being a helper. Helping people to deal with their situation.

F: Let me just ask one more follow up question, I know that you (inaudible) with the group you just mentioned the AIDS Leadership Foothill area Alliance would you be open to receiving information from other agencies within the AME church as well?

P: Oh, yes. I need all I can get.

F: Ok, now that concludes the primary questions for this interview, if you will assist me by answering just a few more background questions that will help us.

Confidential data begins – Selected responses provided.

F: How would you classify most of the churches in your district, urban, suburban, or rural?

P: I would say 10% urban, 30% suburban, and 60% rural.

F: What's the total number of churches in your district?

P: 40

F: And as we collect the rest of this information, we probably will have the information available at the annual conference, and certainly as we prepare information here. What we want to do is really get [to] listen as to where the

persons on the district are regarding this issue. And so if it's okay with you, as we get further along if your time allows, if I touch base with you and keep you abreast of where we are?

P: You may do so, I hope you will.

F: Ok, thank you sir. God bless you.

Tape # 2
Date: 2/27/2004
Facilitator: Reverend Cassandra Sparrow
Pastor/Washington

Facilitator (F): Ok, do you mind if this interview is taped the recorder is now on?

Participant (P): No, I don't mind.

F: Ok, thank you. The responses will be used to assist with understanding data on an Annual Conference Level. Please note that this data is being collected as a part of a Doctor of Ministry project with United Theological Seminary as well as HIV/AIDS project activities of Pilgrim Community Outreach Corporation. Do you have any objections to this interview transcript being used for these purposes?

P: Absolutely not.

F: For any information please contact Reverend Cassandra Sparrow, at XXX-XXX-XXXX and certainly I can give you that after the call.

P: Certainly.

F: There are seven questions and then there are some background questions at the end, [do] you want to get started?

P: I'm ready.

F: Do you recall the HIV/AIDS survey disseminated at the 2003 Midyear conference in Raleigh, NC?

P: Certainly do.

F: Did you complete the survey?

P: That I did.

F: Preliminary assessment shows that approximately 133 surveys were received from

members of the Washington Annual Conference. On a scale of one to five, one being low and five being high, how would you rate the overall readiness of the church you pastor to address HIV/AIDS?

P: Two

F: Could you explain your response?

P: I rate it as two because we had a big change in our wellness ministry and the other focuses within the church have taken priority over the HIV/AIDS readiness program; therefore, I can only give it a two at this point because its on the agenda.

F: Ok, are you aware of any other churches in your area that are engaged in efforts to address HIV/AIDS?

P: None at all.

F: No churches and no agencies?

P: No churches, there is one agency which is the Howard County Health...I' ve forgotten that last name, the Howard County Health Agency or something of that sort. They are located on (inaudible) river, I think and they address issues and we have through one of our ministers, people with questions, along with our wellness group that are taking people and sending people to that location.

F: Related to HIV/AIDS?

P: Correct, I can tell you we' ve only sent two people to my knowledge.

F: Has there ever been a health presentation at the church under your leadership?

P: Yes, it has.

F: How long ago?

P: It was last year.

F: Do you recall what health areas were addressed?

P: Yes, the areas addressed were spirituality and medicine, diabetes and the black community, high blood pressure and the black community, prostate cancer and the black community and we addressed breast cancer and the black community.

F: What about HIV/AIDS, was that ever addressed?

P: No, that was not addressed.

F: That' s important, what do you think the major opportunities are to implementing HIV/AIDS awareness project in your local church?

P: When we have our seminar this year we are having it with the nursing home which is right down the street about two miles, and we have been putting together several issues and that would be a great kind because we would not only touch the people in the church setting but many people in the XXXXXX [city name] proper. And of course, the people that are experts in this area which would really help us out a lot.

F: Any other opportunities?

P: (inaudible) the opportunities, such as church conference, I think that' s a great place to do these things but you know persons must be prepared and I' d be glad to put that on our agenda for the first time at our church conference.

F: Okay. What about challenges, what do you think the major challenges are to HIV/AIDS awareness project in your local church?

P: The major challenges are right in the Howard County community is people in denial it' s no one in their family or them, but they do know neighbors unfortunately so

until we get over the denial thing in Howard County we will always be secondary citizens.

F: Ok, anything else?

P: That' s all that I can think of.

F: Ok, how open are you in your position as Pastor to help raise awareness on HIV/AIDS?

P: When I get the materials that I have an opportunity to read, I will be quite, make it available speak of it from the pulpit and even have (inaudible) committee do the same.

F: What could be done to assist you?

P: Materials that are not as medically oriented as they are practical oriented, and we would be glad to copy them and give them to persons, if necessary, things we put out on our tables in our carousel.

F: Ok, are there any concerns or issues that might hinder your involvement?

P: None that I can think of at the moment.

F: Ok, this concludes the primary questions for this interview. Please assist further by providing additional background information.

Confidential data begins – Selected responses provided.

F: How would you classify the location of your church; urban, suburban or rural?

P: Suburban

F: The size of your congregation, less than 50, 50-150, 150-350, 350-450, or greater?

P: Greater than 450.

F: So like in the 450-700 range?

P: Actually it' s about 700.

Confidential information shared.

F: Well, that concludes the questions thank you sir.

Tape #1
Date: 2/24/2004
Facilitator: Reverend Cassandra Sparrows
Pastor/North Carolina

Facilitator (F): Ok, now the tape recorder is on, do you mind if this interview is taped?

Participant (P): No, I do not mind.

F: Ok, thank you. The responses that you give will be used to assist in understanding data on an annual conference level. Please note that this data is being collected as a part of a Doctor of Ministry Project with United Theological Seminary as well as HIV/AIDS project activities of the Pilgrim Committee Outreach Corporation. Do you have any objection to this interview transcript being used for these purposes?

P: No, I don't.

F: Ok, thank-you. Now, if you need any information about the projects or interviews after this or afterwards you can contact Rev. Cassandra Sparrow, which is me at XXX-XXX-XXXX and what I can do is fax you something. Do you have a fax machine?

P: No, I don't.

F: Ok, I can either fax you something or, you said you don't ,so we'll send you something in the mail so you'll have a copy of this for your records. Well, if it's alright I'll go ahead and begin the questions.

P: Ok.

F: Do you recall the HIV survey disseminated at the 2003 mid year conference in Raleigh?

P: Yes, I do.

F: Ok, did you complete the survey?

P: Yes, I did.

F: Ok. What conference are you in?

P: The North Carolina conference.

F: Ok, You' re in the North Carolina conference. Give me one second, I thought I had the paper in front of me and I just moved it. I was going to give you the number of surveys that was collected from the North Carolina conference. There were 105 surveys collected from both clergy and laypersons. On a scale of one to five, where one is low and five is high, how would you rate the overall readiness of the local church you pastor to address HIV/AIDS?

P: Can you ask me the question again?

F: On a scale of one to five, where one is low and five is high how would you rate the overall readiness of the local church you pastor to address HIV/AIDS?

P: I would say the readiness of the church is probably one.

F: Ok, can you explain that?

P: I would say, one, the people need to be educated concerning HIV before they would even be ready to get that information out to the community, but the body itself would need the education. I just believe that people don' t really know what it is to deal with HIV and AIDS.

F: Ok, thank you. The next question, are you aware of churches or agencies in your area engaged in efforts to address HIV/AIDS?

P: Not to my knowledge ,other than events put on by the health department.

F: Ok, what' s the name of your health [department]?

P: I believe it' s Halifax, I can' t think of the director, but I know it' s Halifax County that we' re dealing with. I live in [confidential data] which is a different county. Most of the things I see on HIV, I see pamphlets, I see, but it' s at a very minimal level. It' s almost like you have to be in those facilities or at a function. The information is not readily available and I do not know of any churches that have a program dealing with that, I am not aware of.

F: Ok, now you' re speaking of churches in general, not just (inaudible)

P: In general.

F: Has there ever been a health presentation at the church under your leadership?

P: No.

F: Ok, fifth question. What do you think the major opportunities are to implementing an HIV/AIDS awareness project in your local church, and your local church still meaning the church where you pastor?

P: I would say connectional wise ,it' s really getting out coming to the forefront in our last pick-up meeting we had before Founders' Day it was asked could we do a workshop at our Easter conference and allow the people, I' m not certain who the group was, but it was concerning HIV/AIDS to come in and do a workshop a brief, probably about an hour long. It' s a segment of the various workshops that we' ll have. To be honest I had a lot of support from the peers, I had a lot of people saying, yes we really need this, but leadership wise it was felt that other things needed to be addressed. So that' s the only connection, I am a part of that on the local setting.

F: Now you said this is at the district conference level.

P: For the district conference level. That's the atmosphere concerning HIV and AIDS at the district conference level that there are more prevalent things, now what those prevalent things are I don't know but that's the things that we heard. And [on] the local level myself as a pastor I have been at this church for about XXXXXXX months, I would say I wouldn't have too much of a problem doing health awareness, HIV/AIDS awareness because I'm for it but I think that's an individual thing. There's not a lot of, there's not a support system as far as the local churches are concerned, where we would readily get information we would have to hunt, we would have to go get it our self, where some would do but most would not because of the scheduling, timing and all that kind of stuff.

F: Ok, scheduling and timing..

P: Also having the resources, having the people power to get that information

F: Let me ask you a question just to follow up. When you said at the district conference level [it] was raised about you having to do a workshop on HIV/AIDS, was that raised by...?

P: It was raised by (inaudible)

F: Ok, it was raised by XXXXXX(?) .

P: Because of what's going on in his church and he's saying basically being in the community that the church is in, and really all of our churches are in the heart of the community basically, and he's having to address these issues and he thought it would be a good thing to have someone come in on the district level and address it to the district conference.

F: Ok, thank you. Now question number six actually [underlines] what I think some of the points you may have already raised but what do you think the major challenges are to HIV/AIDS awareness projects in your local church? The church where you pastor.

P: The challenges are where do I get the proper information and the people power to do that? In other words, if I take it on myself that means I neglect something else, or you know I have to spread myself around so many different places as a pastor that it would take somebody. I would need someone else to help me do it.

F: Ok, anything else?

P: Ummm.

F: In terms of challenges in your local church setting.

P: Another challenge would be getting people to open up to, you know, to even get it out there, to make people comfortable enough to talk about it. The atmosphere is a challenge, and I think that really having someone to team with the pastor or with somebody in the congregation to do it. Because what I' m seeing just as a pastor, I' m seeing that a lot of the times, how to say, my situation being a young pastor the older generation doesn' t always take what I say because I' m younger so having someone with the statistics to back up the pastor or whoever it is presenting the information it' s definitely needed. Not only the age difference, but if somebody in the congregation presents the material you have people looking at them saying, well how do they know and where did they get that information from? So, you have to, on a spiritual tip you

have to steer (inaudible) warfare to get the information out to the people and I think having somebody with experience who already knows all of the preconceived thoughts that we have about HIV and AIDS or the misinformation that we have already we have to combat the because a lot of people have been misinformed or they' ve come to their own information.

F: You are following the questions right as they go.[laughter] The seventh question is how open are you in your position as pastor to help raise awareness on HIV/AIDS?

P: I am very open, very open because I know that it is something that' s going to creep up on the church at an alarming rate.

F: Ok, what could be done to assist you?

P: Actually the thing that I said. The support is really the main thing because I know that our family that know of someone in their family maybe even if it' s extended family that s HIV positive so it would not be that I have any hang-up telling them the information or getting it to them or providing the forum for it but the support is more or less what I would need as a pastor.

F: Now, are there any concerns or conditions that you feel might hinder your involvement?

P: I think the maturity, the spiritual maturity of the people I think that' s the only thing that would be the problem if there' s somebody within the congregation who doesn' t feel that their church is crazy because if you' re talking about prevention or whatever type of program it would be, you would have to touch on some issues that may not well received. If you are going to tell them everything about it, but

if it' s more or less just the medical side of it, if it' s just that. For instance, it' s just like with hypertension if you' re just going to talk about how to live with hypertension that' s one thing, but when you start telling people they need to change their eating habits and exercise and those types of things everybody is not going to want to hear that.

F: So with HIV/AIDS you would say?

P: I would say, one, we have to be aware of what it is and then the way that it' s contracted and then what is the prevention. The prevention, the lifestyle and the things of those nature are the things that I would think more people would be reluctant to just jump out in and talk about, because from what I understand there are lot of people with HIV and they know it but they won' t tell anybody.

F: That was excellent. The seventh question (inaudible)

Confidential data begins –

APPENDIX G

REPORTS TO CONSTITUENTS

"PILGRIM COMMUNITY OUTREACH HIV/AIDS SERIES FOR MEMBER DENOMINATIONS"

Summary Report

Thursday, February 12, 2004

To: **Bishop Vinton R. Anderson,**
Chairman and Members of the Board of Directors,
Second District Religious, Educational, Charitable and Development Projects, Inc. (2nd District RED, Inc.)

From: **Rev. Cassandra A. Sparrow,**
Director, Health and Wholeness Ministries,
Pilgrim Community Outreach Corporation, Inc. (PCOC)

Greetings! On behalf of the Pilgrim Community Outreach Corporation and Rev. Lois A. Poag-Ray, Ph.D., Chairman, I am pleased to provide this summary report. This report covers activities of the project entitled *"Pilgrim Community HIV/AIDS Series for Member Denominations."* The announcement of an award for a $XXXXX subcontract agreement with 2nd District RED, Inc. was made at the October 2003 board meeting in Raleigh, North Carolina. The project is supported through a grant from the U.S. Department of Health and Human Services, Office of Minority Health (OMH). Thank you for your commitment to work with us on this important health initiative. The subcontract agreement has been signed and the initial payment of $XXXXX has been made. We look forward to an exciting and productive project as we work together to continue activities to increase HIV/AIDS awareness through prevention and care activities.

The first official activity of the project involved the conduct of a denominational survey on HIV/AIDS awareness. The following chart summarizes the geographic breakdown of surveys. Analysis is in progress.

Number of Surveys Received during the 2003 Midyear Conference By Annual Conference						
Washington	**Baltimore**	**Virginia**	**North Carolina**	**Western North Carolina**	**Non-Conference Participants**	**Total**
133	63	80	105	86	4	**471**

We all should be pleased with the tremendous response received from persons throughout the Second Episcopal District. This could not have been achieved without the strong leadership and support of Bishop Anderson and members of the Board. It is our request that an opportunity be made during this week's Founder's Day Celebration and Symposium for additional surveys to be disseminated to those persons who may not have previously completed them.

In addition, PCOC in collaboration with the 2nd District RED, Inc. seeks to continue follow-up activities such as in-depth interviews and focus groups with clergy and lay in various locations. PCOC looks forward to the notification of staff to assist with outreach efforts in Virginia, North Carolina and Western North Carolina.

Once again, we are thankful for our joint effort to raise awareness about HIV/AIDS concerns. It is our sincere hope that our work together will make a positive difference in the health and wholeness of individuals, families, congregations and communities.

"PILGRIM COMMUNITY OUTREACH HIV/AIDS SERIES FOR MEMBER DENOMINATIONS PROJECT"

Summary Report

Friday, June 18, 2004

To: **Bishop Vinton R. Anderson,**
Chairman and Members of the Board of Directors,
Second District Religious, Educational, Charitable and Development Projects, Inc. (2nd District RED, Inc.)

From: **Rev. Cassandra A. Sparrow,**
Director, Health and Wholeness Ministries,
Pilgrim Community Outreach Corporation, Inc. (PCOC)

Greetings! On behalf of the Pilgrim Community Outreach Corporation and Rev. Lois A. Poag-Ray, Ph.D., Chairman, I am pleased to provide this summary report. This report covers activities of the project entitled *"Pilgrim Community HIV/AIDS Series for Member Denominations."* A subcontract agreement with 2nd District RED, Inc. was established in October 2003 for the period through April 2004. An extension of the project through August 31, 2004 has been granted from the U.S. Department of Health and Human Services, Office of Minority Health (OMH). Special thanks and appreciation is extended to Bishop Anderson for his steadfast leadership in raising health awareness in numerous forums. In addition, we are most grateful for the expertise and technical assistance of Mrs. Jacquelyn Dupont-Walker, Board Member and Executive Aide. The work with the 2nd District RED and its Board of Directors continues to be instrumental in ensuring that we are strategically positioned to increase HIV/AIDS awareness through prevention and care activities among African Methodist Episcopal (A.M.E.) Church congregations and communities in the region.

Key activities conducted since the last reporting period in February 2004 are as follows:

1. Presentation on the project at the monthly meeting of the A.M.E. Ministerial Alliance for the Washington Conference (February 2004);

2. Action Alerts mailed to churches in the Baltimore and Washington Annual Conference to encourage support of the Black Church Week of Prayer for the Healing of AIDS (February-March 2004);

3. Workshop at the Southern District Conference of the North Carolina Annual Conference (March 2004);

4. Exhibit booths at each Annual Conference: Baltimore, Washington, Virginia, North Carolina and Western North Carolina (April – June 2004);

5. Presentation and dissemination of materials as a part of the Social Action and Community Action Committee Reports of the North Carolina and Western North Carolina (May – June 2004);

6. Initial identification of churches and clergy and lay leaders in each Annual Conference who have either already conducted HIV/AIDS awareness activities, expressed interest in doing so, or that have been recommended as possible participants in the project;

7. In-depth interviews with Presiding Elders and Pastors in each of the five Annual Conferences; and

8. Preliminary analysis of the **582** "HIV/AIDS Surveys" that were disseminated throughout the Second District.
   Note: The surveys were administered in the following settings: 12 survey from the pilot, 471 surveys from the 2003 Midyear Conference, 99 from the Southern District Conference, North Carolina Annual Conference and a Washington Annual Conference local church. In addition, other recently completed surveys have not been included in the above statistics.

Future Work

PCOC in collaboration with the 2nd District RED, Inc. looks forward to continuing to conduct follow-up activities in various locations, particularly Virginia, North Carolina and Western North Carolina where assistance was initially requested.

Work in the coming months emphasizes three areas:

- Modification of the subcontract to meet needs during the extension period through August 31, 2004;

- In-depth interviews and focus groups with clergy and lay; and

- Workshops, presentations and information dissemination throughout the Second District.

Invitations were received during the season of the Annual Conferences to do further work with persons engaged in outreach to youth and young adults, prison ministries and other outreach activities. In addition, project representatives were invited to do a plenary session at the Second District Fall Lay Organization meeting scheduled for the Fall 2004 in Charlotte, NC.

Once again, we are thankful for our joint effort to raise awareness about HIV/AIDS concerns. With God's blessings and our enthusiasm and hard work, our work together will continue to make a positive difference in the health and wholeness of individuals, families, congregations and communities.

"PILGRIM COMMUNITY OUTREACH HIV/AIDS SERIES FOR MEMBER DENOMINATIONS PROJECT"

Summary Report (Revised)

Monday, October 25, 2004

To: **Bishop Vinton R. Anderson,**
Chairman and Members of the Board of Directors,
Second District Religious, Educational, Charitable and Development Projects, Inc. (2nd District RED, Inc.)

From: **Rev. Cassandra A. Sparrow,**
Director, Health and Wholeness Ministries,
Pilgrim Community Outreach Corporation, Inc. (PCOC)

Greetings! On behalf of the Pilgrim Community Outreach Corporation and Rev. Lois A. Poag-Ray, Ph.D., Chairman, I am pleased to provide this summary report. This report covers activities of the project entitled *"Pilgrim Community HIV/AIDS Series for Member Denominations."* A subcontract agreement with 2nd District RED, Inc. was established in October 2003 for the period through October 31, 2004. The project is supported through a grant from the U.S. Department of Health and Human Services, Office of Minority Health (OMH). Special thanks and appreciation is extended to Bishop Anderson and to Mrs. Jacquelyn Dupont-Walker, Board Member for their support of the project. The work with the 2nd District RED and its Board of Directors continues to be instrumental in ensuring that we are strategically positioned to increase HIV/AIDS awareness through prevention and care activities among African Methodist Episcopal (A.M.E.) Church congregations and communities in the region.

Key activities conducted since the last reporting period in June 2004 are listed in the section that follows. PCOC is most appreciative for the communication with the new Second Episcopal District Leadership, Bishop Adam Jefferson Richardson, Jr. and Mrs. Connie Speights Richardson. Discussions have been inspiring and pro-active. We look forward to the work ahead.

Recent Activities

1. Continued communication with clergy and lay leadership at the Second Episcopal District Planning Meeting in Portsmouth, Virginia (August 2004)

2. Meeting to review project and discussion of plans for HIV/AIDS outreach with Bishop Richardson and Mrs. Richardson, Rev. Dr. Poag-Ray and PCOC staff (August 2004)

3. Presentation at the Second Episcopal District Lay Organization's Executive Board Meeting in Richmond, Virginia and follow-up conference calls with Dr. Cellestine Cheeks (2nd District President) and Annual Conference Lay Organization Presidents (August 2004)

4. Planning and initial taping for DVD to be used for HIV/AIDS outreach purposes within the Second District. Technical assistance provided by Urban World Productions and Keith E. Andrews, II, Executive Producer. Clergy and lay leaders as well as youth were interviewed. An A.M.E. nurse and a medical doctor were also among those interviewed. (October 2004)

5. In-depth interviews with Bishop Richardson and Mrs. Connie Richardson on the HIV/AIDS initiative. (September and October 2004)

Future Work

- Presentation at the Second District Lay Organization Conference in November 2004 in Atlantic Beach, North Carolina.

- Follow-up with Social Justice and Community Action Committees of the Annual Conferences especially where HIV/AIDS awareness was included in resolutions (e.g., North Carolina and Western North Carolina).

- Continue identification of churches and clergy and lay leaders in each Annual Conference who either already conducted HIV/AIDS awareness activities, expressed interest in doing so, or that have been recommended as possible participants in the project.

- Continue in-depth interviews with Presiding Elders and Pastors in each of the five Annual Conferences

- Workshops, presentations and information dissemination throughout the Second District.

As always, we are thankful for our joint effort to raise awareness about HIV/AIDS concerns. With God's blessings and our enthusiasm and hard work, our efforts together will continue to make a positive difference in the health and wholeness of individuals, families, congregations and communities.

"PILGRIM COMMUNITY OUTREACH HIV/AIDS SERIES FOR MEMBER DENOMINATIONS PROJECT"

Summary Report

Thursday, February 10, 2005

To: **Bishop Adam J. Richardson, Jr.,**
Chairman, and Members of the Board of Directors,
Second District Religious, Educational, Charitable and Development Projects, Inc. (2nd District RED, Inc.)

From: **Rev. Cassandra A. Sparrow,**
Director, Health and Wholeness Ministries,
Pilgrim Community Outreach Corporation, Inc. (PCOC)

Greetings! On behalf of the Pilgrim Community Outreach Corporation and Rev. Lois A. Poag-Ray, Ph.D., Chairman, I am pleased to once again provide this summary report. It is a joy to announce the continued growth and development of health awareness initiatives under the dynamic and committed leadership of Bishop Richardson and Episcopal Supervisor Connie S. Richardson. This report covers activities of the *Pilgrim Community HIV/AIDS Series for Member Denominations Project."* A subcontract agreement with 2nd District RED, Inc. was established in October 2003 for the period extended through February 28, 2005. The U.S. Department of Health and Human Services, Office of Minority Health (OMH) continues to provide project funding.

The Second District is strategically positioned to increase HIV/AIDS awareness through prevention and care activities among African Methodist Episcopal (A.M.E.) Church congregations and communities. Key activities conducted since the October 2004 reporting period are listed in the section that follows.

Recent Activities

1. *Dissemination of 500 copies of the 2004-2005 Second District HIV/AIDS Awareness Action Packet* to pastors at the Midyear Conference, 2nd Episcopal District Lay Organization Conference and the Capitol District Conference, Washington Annual Conference. (October – November 2004)

2. *The Honorable Claude Allen, Deputy Secretary, U.S. Department of Health and Human Services*, delivered a thought-provoking speech at the Midyear Conference in Raleigh, North Carolina. This was a historic occasion (October 2004)

3. *Presentation at the Second Episcopal District Lay Organization Conference in Atlantic Beach, North Carolina.* We are most appreciative to the Dr. Cellestine Cheeks (2nd District President) and Annual Conference Lay Organization Presidents and other members (November 2004)

4. *Completion of taping for the first DVD for the project entitled "HIV/AIDS Awareness: A Call to Action."* Bishop and Mrs. Richardson, colleagues from Florida A & M University including Rev. Maria Mallory White and Dr. John W. Chambers are featured. In addition, Rev. Lucille Norville-Perez, M.D. provides a medical perspective. This DVD is scheduled for release at the closing session of Founders' Day. *Five hundred DVDs will be available for each 2nd District RED Board Members as well as one copy per church.* Urban World Productions - Las Vegas and Florida A & M School of Journalism, Media and Graphic Arts provided leadership to the project.

5. *World AIDS Day activities were conducted throughout the 2nd Episcopal District to respond to the call to action of Bishop and Mrs. Richardson.* Examples of activities conducted include the conduct of worship services and prayer meetings, HIV testing, workshops, and dissemination of awareness materials (December 2004)

6. *Periodic meetings with Bishop Richardson and Mrs. Richardson* to review project and discussion of plans for HIV/AIDS outreach (Ongoing)

7. *Submission of an application for a five-year diabetes project to the Centers for Disease Control and Prevention (CDC).* A late February announcement is anticipated.

Future Work

- Continued editing and completion of additional taping for the second HIV/AIDS awareness DVD. This DVD will include various perspectives of laypersons, youth and local churches. Final production is planned for release during the 2005 Annual Conferences.

- Follow-up with Social Justice and Community Action Committees of the Annual Conferences especially where HIV/AIDS awareness was included in resolutions (e.g., North Carolina and Western North Carolina).

- Completion of report of HIV/AIDS survey results, and in-depth interviews with Presiding Elders and Pastors in each of the five Annual Conferences.

- Continued conduct and support of workshops, presentations and information dissemination throughout the Second District.

Praise and thanks to God for all that we have been able to accomplish together to raise awareness on HIV/AIDS. Please continue to pray that individuals, families, congregations and communities will continue to feel the positive impact of our joint efforts.

APPENDIX H

SELECTED SECOND EPISCOPAL DISTRICT EDUCATIONAL AND PROMOTIONAL MATERIALS

THE PILGRIM COMMUNITY OUTREACH CORPORATION, INC.
1648 Rosedale Street, N.E.
Washington, DC 20002
Phone: (202) 388-9100

Rev. Lois A. Poag-Ray, Ph.D., Chairman
Rev. Cassandra A. Sparrow, Director, Health and Wholeness Ministries

OVERVIEW

Project Titles: "Faith Outreach for HIV/ AIDS Project" and " Pilgrim Community Outreach HIV/AIDS Series for Member Denominations Project"

Target Population: The Faith Outreach Project includes outreach to African-American clergy and lay leadership in the District of Columbia, Maryland, and New York (Harlem), New York.

The Member Denominations Project focuses on the five conferences in the Second Episcopal District of the African Methodist Episcopal (AME) Church: Baltimore,

Washington, Virginia, North Carolina, and Western North Carolina Conferences.

Project Activities: Activities to increase HIV/AIDS prevention and care occurring in Harlem, NY through services of the Health Resource Library and participation of 50 member churches of the

Harlem Congregations for Community Improvement, Inc. (HCCI). Outreach efforts in the Washington, DC metropolitan area through collaboration with affiliated agencies and churches. Examples of affiliated entities include: Pilgrim AME Church & the Pilgrim

AME Job Connection, Greater Mt. Nebo AME Church & the Richard Alien Community

Development Corporation, Lee Memorial AME Church). Activities to increase the understanding of current awareness levels of HTV/AIDS prevention and care occurring in the 2" Episcopal District (e.g., surveys, focus groups, interviews) in conjunction with the

Second District Religious, Educational and Charitable Development Projects, Inc.

Technical assistance will be provided to increase the number and types of HIV/AIDS awareness activities conducted by denominational leadership and churches.

HIV/AIDS FACTS

• Of the estimated 40,000 new HIV infections each year, more than 50 percent occur in African Americans.

• In 1998, African American women constituted 64 of new female AIDS cases. African American men accounted for 50 of new AIDS cases among men.

• AIDS is the number one cause of death for Black adults aged 25-44, before heart disease, cancer and homicide.

• One in 50 Black men is HIV-positive. One in 160 Black women is HIV-positive.

• Black senior citizens represent more than 50 of HIV cases among persons over 55.

• Intravenous drug use is fueling the epidemic in Black communities. It accounts for43 of infections among Black women and 38 among Black men. Many women contract HIV infection through sex with an injection drug user.

• In 1998, men of color who have sex with men represented 52 of total AIDS cases. By comparison, in 1989 men of color who have sex with men represented 31 of AIDS cases

. • Although only 15 of the adolescent population in the United States is Black, over

60 of AIDS cases reported in 1999 among 13-19 year olds were among Blacks.

• Black children represent almost two-thirds (62%) of all reported pediatric AIDS cases.

• AIDS is a global problem among Black people. The World Health Organization reveals that the disease is the number one leading cause of death in Africa. The

United Nations estimated that two million Africans died of AIDS in 1998, accounting for 80 of the worldwide total of AIDS deaths. Nine out often children with HIV area in sub Saharan Africa. By the end of the year 2000, a cumulative total of 13 million children-the majority in Africa will have lost one or both parents to AIDS.

Sources: Data provided by the U.S. Centers for Disease Control and Prevention; Harvard AIDS Institute

Bishop Vinton R. Anderson, Chairman

The Second District Religious, Educational,
Charitable and Development Projects, Inc.

in collaboration with

The Pilgrim Community Outreach
Corporation, Inc.
Rev. Dr. Lois A. Poag-Ray, Chairperson

Encourages You and Your
Congregation To Regularly Engage in
Health and Wholeness
Activities.

Please remember HIV/AIDS is on the
rise in the African American
Community.

GET INVOLVED with
HIV/AIDS Prevention and Care
Today!

PILGRIM COMMUNITY OUTREACH CORPORATION, INC.

HIV/AIDS *Series for Member Denominations Project*

ACTION ALERT

THE BLACK CHURCH WEEK OF PRAYER FOR THE HEALING OF AIDS

March 7-13,2004

The Black Church Week of Prayer for the Healing of AIDS, sponsored by The Balm In Gilead, Inc. is a week long observance of prayers for the eradication of AIDS among African peoples everywhere, as well as a time to share understanding of the effect the disease has had, and the impact it will continue to have without prevention and education. Prayer begins on the first Sunday in March and continues for seven days in African American communities across this country as well as in Africa. The Black Church Week of Prayer for the Healing of AIDS is a vehicle for spiritual renewal, transformation and education for every individual and church community that participates.

AIDS is the leading cause of death for African Americans ages 25 - 44. Currently AIDS is also the leading cause of death in many African countries. AIDS has reduced life expectancy (e.g., in Kenya, life expectancy has dropped due to AIDS from 63 to 45 years), leaving orphaned children to fend for themselves in an environment increasingly empty of healthy adults. It is projected that in the next decade AIDS will orphan almost one half of all Zimbabwean children, and half of those orphans will be HIV positive.

How To Participate In The Week Of Prayer For The Healing Of AIDS

Suggestions/or making AIDS education the focus of your -worship experience:

- During worship, offer a special prayer for the healing of AIDS - its impact on our family, community and throughout the global village.
- The pastor can deliver a compassionate and informative sermon on HIV/AIDS and the role of the church.
- Include AIDS facts in your Sunday bulletin and/or distribute AIDS education brochures from AIDS service organizations or the local health department.
- Include a discussion of AIDS education in the church school program at every age level.

Suggestions for-educational activities you can provide at the church during the week:

- Host a prayer vigil and distribute AIDS information.
- Conduct an AIDS prevention workshop for youth and/or adults.
- " Host a church conference on AIDS for the community.

• Host a workshop on mobilizing volunteers for AIDS service. Source: The Balm In Gilead, Inc., www.bamiingilead.org You can receive more program suggestions and further assistance by contacting:

Reverend Karen Young
Manager
Pilgrim Community Outreach Corporation
Health and Wholeness Ministry
1648 Rosedale Street, Northeast
Washington, DC 20002
Telephone: 202-388-9100
Fax: 202-388-9103
Email:
www.kyoung@pilgrimcoc.org

10th LAY CONVENTION SESSIONS

Key Sessions: General/Special Sessions

- Bible Study - Bro. Richard Hunter
~ Worship & Communion Service - Bishop Adam J. Richardson, Jr
~ Awards Banquet - Bro. Jesse Bums, Speaker
- Prayer Breakfast - District Young Adults
~ Memorial Service - District Young Adults
-Plenary Session- Dr. Cellestine Cheeks & Sis. Adrienne Warren
~ Closing Session - Dr. Cellestine Cheeks

Concurrent Sessions

~ Ministering: Called, But Not to Preach - Rev. Ronald Boykin & Sis. Helen Boykin
~ Reflections from Gerneral Conference: Strategic Planning – Sis. Paulette Smith-Bryant
~ Up Close A Personal: Q & A with the Presiding Prelate - Bishop A. J. Richardson
~ Young Adult Leadership in the Local Church – Bro. Douglas Bynum
~ A Healthy 21st Century Church: HIV/AIDS in the African American Church & Community-Rev. Cassandra Sparrow & Sis. Linda Carter
~ Technology, Young Adults & the Church- Rev. Brandon Davis

Pre-Convention Sessions

- Executive Board Meeting - Dr. Cellestine Cheeks
- Conference DLA Meeting - Sis. Adrienne Warren
~ Committee Meetings- All Chairpersons
~ All Presidents Meeting - Dr. Cellestine Cheeks & Vice Presidents

Special Interest Workshops

~ First Timers Session - Sis. Adreinne Warren
~ Growing Your Lay Organization (All) - Sis. Florence Warren
~ Technology 101(A11) - Sis. Edith Thomas
~ The Internet and You (All)- Sis. Kim Adams & Sis NeKeisha Sylver
~ Traming& Development: Making Presentations Meaningful –Dr. V. Susie Oliphant

African Methodist Episcopal Church

Second Episcopal District

Midyear Meeting 2004



October 26 - 28, 2004

North Raleigh Hilton Hotel
Raleigh, North Carolina

St. Paul AME Church, Host Church
402 Edenton Street
Raleigh, North Carolina 27603

The Rev. Gregory L. Edmond, Host Pastor

The Rev. J. Bernard Wilder, Host Presiding Elder The Rt. Rev. Adam Jefferson Richardson, Jr., Presiding Bishop
Mrs. Connie Speights Richardson, Episcopal Supervisor

10:30 a.m. **COMPONENT MEETINGS**

- Board of Examiners
- Women's Missionary Society
- RAYAC
- Family Life Ministry
- Evangelism
- Nehemiah Ministry
- Debutante-Masters Commission

12:30 p.m.

2:00 p.m. **COMPONENT MEETINGS**

- Young People's Division
- District Lay Organization
- Women in Ministry
- Spouses and Widows Alliance
- Clergy Caucus
- Social Action
- Sons of Allen
- Theological Scholarship Fund

5:30 p.m.

7:00 p.m. **Dorcas Exteravaganza**

Mrs. Connie S. Richardson
Supervisor, WMS

Mrs. Katherine Fisher
Episcopal President, WMS

Mrs. Shirley Sheares
Chair, Dorcas Event

Thursday, October 28

8:00 a.m. Founder's Day Planning Committee

9:00 a.m. Devotion

9:30 a.m. Component Reports

10:00 a.m. The Honorable Claude Alien, Deputy Secretary United States Department Health and Human Services

Report of Finance Committees

Convocation Wrap-up

11:00 a.m. Calendar Review

11:30 a.m.

12:00 p.m. Closing Meditation

This day is in memory of our loved ones we have lost to HIV/AIDS and in honor of those who still fight the day to day battle of HIV/AIDS.



We, The Liberating Love Ministry, would like to dedicate this service to the memory of Dr. Charles T. Williams, a former member of Bethel AME Church and The Liberating Love Ministry.

WORLD AIDS DAY SERVICE



December 1, 2004 - 6:30 p.m.

Bethel AME Church
1300 Druid Hill Ave
Baltimore, MD 21217
(410) 523-4273

Dr. Frank M. Reid, III - Chief Spiritual Officer



NOTES

WORSHIP SERVICE

Opening Hymn	*"Blessed Assurance" #450*
Prayer	
Scripture	
Selection	**Bethel AME Church Music Ministry**
Welcome	
Response to Welcome	
Remarks	***Mr. Terry Brown*** Co-Chair of the Baltimore City Commission on HIV/AIDS and a member of the MD State Council on Drug & Alcohol Abuse
Offering	
Introduction of Speaker	
Selection	*"There Is a Balm in Gilead"* **#425**
Inspirational Message	***Rev. Cassandra A. Sparrow*** Lee Memorial AME Church
Testimony	***Ms. Kim Day*** Coordinator of HIV Counseling and Testing of the Chase- Brexton Health Center
Remarks	Liberating Love Ministry of Bethel AME Church
Benediction	

Office of the Bishop

AFRICAN METHODIST EPISCOPAL CHURCH - 2ND EPISCOPAL DISTRICT

THE RT. REV. ADAM JEFFERSON RICHARDSON, JR.
Presiding Bishop

MRS. CONNIE S. RICHARDSON
Supervisor, Women's Missionary Society

1134 Eleventh Street, NW • 3rd Floor Suite • Washington, DC 20001
Telephone: 202.842.3788 • Fax: 202.289.1942 • Email: prichardson@2ndamec.org

A MESSAGE
FROM THE BISHOP AND EPISCOPAL SUPERVISOR

Dear Friends,

It is important that on our historic Founders' Day celebration that the Second Episcopal District of the African Methodist Episcopal (AME) Church unveil this HIV/AIDS Awareness DVD. In the true spirit of legacy of our founder, Bishop Richard Allen, we promote health and well-being of all persons. During the 1793 yellow fever epidemic in Philadelphia, Pennsylvania, the AME church led by Allen and others organized efforts to care for the sick and bury the dead.[*] Time and resources were devoted to relentlessly assist the local government and those in the medical profession to respond to the crisis.

Today, we tackle HIV/AIDS, another public health issue that threatens to test our resolve to always put our faith into action. Our collective task is to serve God and humanity. In love, we must continue to render prevention and care services to those infected and affected by HIV/AIDS in our congregations and communities. We are pleased to work in collaboration with the Second District Religious, Educational and Charitable Development Projects, Inc. (2nd District RED), Pilgrim Community Outreach Corporation and the U.S. Department of Health and Human Services, Office of Minority Health.

It is our sincere prayer that Second District congregations will be pro-active in continuing to uphold the legacy of the AME Church. Take action in 2005 and beyond to raise HIV/AIDS awareness. Please review and share this DVD with those in your community. May God bless us as we make a difference promoting the health and wholeness of the people of the United States and citizens of the world.

Yours in His service,

Bishop Adam J. Richardson, Jr.

Mrs. Connie S. Richardson

[*] Reference: Klots, Steve. *Richard Allen: Religious Leader and Social Activist.* New York: Chelsea House Publishers, 1991.

THE SECOND EPISCOPAL DISTRICT AFRICAN METHODIST EPISCOPAL CHURCH

THE SECOND DISTRICT RELIGIOUS, EDUCATIONAL AND CHARITABLE DEVELOPMENT PROJECTS, INC. (2nd District RED, Inc.)

IN COLLABORATION WITH

THE PILGRIM COMMUNITY OUTREACH CORPORATION (PCOC)

2004-2005
HIV/AIDS AWARENESS
ACTION PACKET



The Rt. Rev. Adam Jefferson Richardson, Jr, Presiding Bishop
Mrs. Connie Speights Richardson, Episcopal Supervisor

THE RT. REV. ADAM JEFFERSON RICHARDSON, JR.
Presiding Bishop

Mrs. CONNIE S. RICHARDSON
Supervisor, Women's Missionary Society

October 19,2004

Dear Friends and Members of the Second Episcopal District:

Greetings! At the August Planning Meeting in Portsmouth, I set forth a seven-point vision for the District. An emphasis was placed on increasing HIV/AIDS awareness. While serving in Africa, my wife and I had first-hand experience seeing the devastation that HIV/AIDS has upon individuals, families, congregations and communities. Thus, we are pleased to join with you in the good work being accomplished through the Religious, Educational and Charitable Development Projects, Inc. of the Second Episcopal District (2nd District RED, Inc.). This work includes the Pilgrim Community Outreach Corporation. Through our collaboration, and with support from the Office of Minority Health, we will be faithful and resolute in promoting health in the Episcopal District and as far as our reach will allow.

The Second District HIV/AIDS Awareness Action Packet consists of information to assist in mobilizing congregations to increase our expressions of compassion to infected persons, and others who are affected. With firm resolve, we can make a difference in the lives of many across the five Annual Conferences which comprise the Second District. Please join me in committing ourselves to action. World AIDS Day is Wednesday, December 1, 2004. Let me encourage you to speak to the issues related to the AIDS pandemic on Sunday, December 5, 2004 during your worship services.

To assist with your preparation, we have included a worship outline with prayer and litany. The components of the Action Packet are designed to support World AIDS Day and other awareness days. The information may also be incorporated into the outreach activities and continuing ministries of your local church. Along with this cover letter, please take note of the following items:

1. HIVA1DS Fact Sheet
2. Council of Bishops' Statement on HIV/AIDS (2002)
3. Liturgical materials (a service outline and starter)
4. Overview of results from the HIV/AIDS Survey conducted at the 2003 Midyear Meeting
5. Action Alert for World AIDS Day, December 1, 2004

It is my hope that you will be proactive in addressing this pandemic, being compassionate as we see the faces of the affected, to enlarge our understanding of human sexuality, and that we will be committed to caring for all of God's children. Let me say again, how thrilled Mrs. Richardson and I are about being set apart for service in the Second District. Continue to pray/or us and with us for the comprehensive ministry of the Second District.

Yours in His Service,

Adam J. Richardson, Jr.
Bishop

Letterhead did not scan to see heading and footer.

African Methodist Episcopal Church Council of Bishops

The African Methodist Episcopal Church recognizes HIV/AIDS to be a health crisis of pandemic proportions. It is a threat to the social, economic and political fabric of our constituents, their extended families and to communities and venues where the AME Church has presence. We are calling on legislative bodies, public and private healthcare providers, and AME Church members to aggressively respond to the urgency of the clear and present danger this malady represents. Indeed, this malady pierces the comfort zones and security of all. No longer is it tenable that ecclesiastical silence and theological indifference can suffice as a politically correct or socially acceptable response. This scourge of our time must be dealt with cogently, compassionately and completely within a holistic framework that does not condemn nor cast judgment upon a victim. Our response must inspire hope, faith and love. The church must be on the frontline of battle in providing appropriate leadership in response to a crisis that is especially dominating African and African American Communities and decimating families worldwide.

Since 1985, the AME Church has actively been involved in the fight against the spread of AIDS. Between 1985 and 1992, eleven Centers began operating in Florida. Since 1998, Centers have been operating in Southern Africa. The African Methodist Episcopal Church, beginning as the Free African Society in 1787, has been in the vanguard against the enemies of the health, liberation, education and well-being of people in communities where there is an AMEC presence around the world. With these Centers, the church continues to provide financial and moral support as tangible responses to the AIDS crisis.

Philip Robert Cousin, Senior Bishop

Vashti Murphy McKenzie, Council President

and

Bishops John Richard Biyant, Richard Alien Chappelle, Sr., McKinley Young, Robert Vaughn Webster, Comal Gamett Henning, Sr., William Phillips DeVeaux, Theodore Larry Kirkland, Adam Jefferson Richardson, Jr., Richard Franklin Norris, Gregory G. M. Ingram, Preston Warren Williams, II, Wilfred J. Messiah, Paul J. Kawimbe, Carolyn Tyier Guidry, James Lavert Davis, Samuel L. Green, Sarah F. Davis, David R. Daniels, E. Earl McCloud

and

Retired Bishops Decatur Ward Nichols, Henry Wendell Murph, John Hurst Adams, Richard Alien Hildebrand, Frederick Hilbom Talbot, Hamel Hartford Brookins, Vinton Randolph Anderson, Frederick Calhoun James, Frank Curtis Cummings, Cornelius Egbert Thomas, James Haskell Mayo, Henry Alien Belin, Jr., Vemon Randolph Byrd, Harold Ben Senatle, Robert Thomas, Jr., Zedekiah LaZett Grady

The Council of Bishops African Methodist Episcopal Church Bishop Adam J. Richardson, Jr., President Tampa, Florida June 24, 2002

Nineteenth Episcopal District African Methodist Episcopal Church Mid-Quadrennial HIV/AIDS Convocation Johannesburg, South Africa December 4-6, 2002

The Call and Challenge to Heal the Land

A Service of Hope and Healing for HIV/AIDS

The Doxology

The Call to Commitment (Read in Unison)

Church, we are the Body of Christ,
The Body of Christ, living with AIDS.
If we choose, we can make a difference.
If we choose, we con contribute to the healing of AIDS.
In our homes, in our church, in our community
In our bodies, in our minds, in our spirits.
Our sisters and brothers, our parents and children are infected with HIV.

Our community is living and dying with AIDS.
If we choose, the blocks to healing can be removed.
We choose compassion.
We choose to respond.
Will you respond with your money, with your time, with your love?
We are the Body of Christ.
We choose to respond so that AIDS may be healed.
We pray and act for the healing of AIDS.

(Copyright 1997, The Balm in Gilead, Inc)

The Hymn

The Prayer of Invocation

Holy and eternal God, we affirm Your sovereignty over all the earth as Lord of Creation, Redeemer, Reconciler, and Compassionate Friend. We gladly, but humbly, invoke Your presence among us. We declare our need of You and therefore we pray. You are welcome in this place. We confess our sins, by thought, word and deed. We confess that we have made a mess of Your creation, even Your gift of sex. We repent, heartily sorry for the things that have grieved You. Unwittingly, we have invited death into our beds. Gracious God, forgive us. Heal the land by Your gracious mercy. Speak life to us again. Speak compassion into our hearts that we will not stigmatize those of us who are infected with HIV. Help us to care. Inspire us to give - of our time and resources with concern for others. As we are prone to sin - even at our own peril, inspire us to change - our behavior and our attitudes. Bless every worshipper today. Bless every affected home where there is infection. Bless every researcher - give to us a breakthrough that will save the lives of millions around the world. Bless every caregiver with the gift of healing in their hands, hopeful attitudes on their countenance, and efficacy in the medicines they dispense. Bless those who are in despair and hurting that they may leave here today hopeful. We bless Your name. We will give You the glory for the healing we expect to receive from You. We pray in the name of the glorious Christ, our Healer and Savior, Your Son. Amen.

The Prayer Response " I Need Thee Every Hour"

The Reading of Holy Scripture

Our Call to Morality and Responsibility

If My people, who are called by My name, will humble themselves and pray And seek my face and turn from their wicked ways, then will I hear from Heaven and will forgive their sin and will heal their land. 2 Chronicles 7:14

Our Challenge to Care for the Infected and Affected

... He [Jesus] drove out the spirits with a word and healed all the sick. Matthew 8:16

Our Hope for a Future with Global Healing

On each side of the river stood the tree of life ... And leaves of the tree are for the healing of the nations. Revelation 22:2

A Litany of Life

Leader: Church, we are the Body of Christ living with AIDS.
People: We wear the red ribbon because we care.
Leader: Church, we are the Body of Christ living with AIDS.
People: We wear the red ribbon as a sign of hope.
Leader: Church, we are the Body of Christ living with AIDS.
People: We wear the red ribbon because we are concerned.
Leader: Church, we are the Body of Christ living with AIDS.
People: We wear the red ribbon in compassion for those infected and affected,
Leader: Church, we are the Body of Christ living with AIDS.
People: We wear the red ribbon in support of finding a cure.
ALL: Church, we are the Body of Christ.

(From Bethel AME Church, Shreveport, Louisiana - Dr. Herman 0. Kelly, Pastor)

The Proclamation of the Word

The Invitation to Christian Discipleship

The Call to a Prayer of Intercession

The Doxology The Benediction

(This service outline was prepared by Bishop Adam J. Richardson, Jr. and originally used as the closing meditation of the 19th District Mid-Quadrennial Convocation and International Conference on HIV/AIDS, Johannesburg, South Africa, December 2002.)

"PILGRIM COMMUNITY OUTREACH HIV/AIDS SERIES FOR MEMBER DENOMINATIONS PROJECT'

OVERVIEW OF HIV/AIDS SURVEY RESULTS 2003 MIDYEAR CONFERENCE

The 2003 Midyear Conference HIV/AIDS Survey was made possible by a subcontract agreement between the Pilgrim Community Outreach Corporation (PCOC) and the Second District Religious, Educational and Charitable Development Projects, Inc. (2nd District RED, Inc.). The overall HIV/AIDS project is supported through a grant from the U.S. Department of Health and Human Services, Office of Minority Health (OMH). The survey was disseminated at the October 30, 2003 2nd District RED, Inc board meeting and the Closing Session of the Midyear Conference on November 1, 2003 in Raleigh, North Carolina. The purpose of the confidential survey was to determine the educational needs of lay and clergy within faith-based institutions regarding HIV/AIDS, namely the 2nd Episcopal District of the African Methodist Episcopal Church. Thank you for your commitment to work with us on this important health initiative. We look forward to an exciting and productive project as we work together to continue activities to increase HIV/AIDS awareness through prevention and care activities across the 2nd Episcopal District. The first official activity of the project involved the conduct of a denominational survey on HIV/AIDS awareness. The following chart summarizes the geographic breakdown of surveys. Analysis is in progress.

Number of Surveys Received during the 2003 Midyear Conference By Annual Conference						
Washington	Baltimore	Virginia	North Carolina	Western North Carolina	Non-Conference Participants	Total
134	63	80	104	86		471

NOTE: *Some persons did not complete every question on the survey. Thus, missing data accounts for some of the differences in results. For example, the number of persons responding to a given category or question may not equal the total surveys received by an Annual Conference and percentages may not total 100%.*

SNAPSHOT OF PERSONS RESPONDING

- 144 Clergy and 286 Laypersons, Approximately 41 persons did not respond to the question

  Baltimore - 10 Clergy, 47 Lay, Washington - 44 Clergy, 80 Lay, Virginia - 17 Clergy, 55 Lay North Carolina - 34 Clergy, 59 Lay, Western North Carolina - 39 Clergy, 41 Lay
- Age Range: 21-90, with the mean age of 61 and median age as 58, Standard Deviation was 17

PILGRIM COMMUNITY OUTREACH CORPORATION, INC.

HIV/AIDS Series for Member Denominations Project

ACTION ALERT

WORLD AIDS DAY - DECEMBER 1, 2004

"Have You Heard Me Today? Women, Girls, HIV and AIDS"

According to estimates of the United Nations Program on HIV/AIDS (UNAIDS) there were 35.7 million adults and 21 million children living with HIV at the end of 2003 and during this year 4.8 million new persons will become infected with the vims Around half of the people who become infected with HIV do so before they are 25 years old and are tailed by AIDS before they reach age 35. Ninety-five percent of the total number of people with HIlV/AIDS live in the developing nations. HIV remains a threat to people of all ages and nationalities.

Each year. World AIDS Day is observed on December 1. "Have You Heard Me Today? Women, Girls, HIV and AIDS" is this year's theme. Women now make up half the people living with HIV. Globally, women and girls are being infected with HIV at a faster rate than men and boys. This year's UNAIDS campaign focuses on women and girls -preventing new infections, promoting equal access to treatment and mitigating the impact of AIDS. According to a new UN report, "HIV/AIDS is no longer striking primarily men Today, more than twenty years into the epidemic, women account for nearly half the 40 million people living with HIV worldwide. In sub-Saharan Africa, 57 percent of adults with HIV are women, and young women aged 15 to 24 are more than three times likely to be infected as young men. Despite this alarming trend, women know less than men about how HIV/AIDS is transmitted and how to prevent infection, and what little they do know is often rendered useless by the discrimination and violence they face.

How Your Church Can Support World AIDS Day 2004

- During worship on Sunday, December 5, 2004 offer a special prayer for women and girls around the world who are infected by the HIV virus.
- Wear red ribbons and ask others to do the same.
- Include AIDS facts in your Sunday bulletin and/or distribute AIDS education brochures and fact sheets from AIDS service organizations or the local health department. Some of this information may be found in the 2004-2005 Second District HIV/AIDS Awareness Action Package.

•Make a donation to an AIDS charity

•Conduct an HIV/AIDS prevention workshop for girls and women.

•Put up a bulletin board or display on HIV/AIDS.

•Host a church conference on HIV/AIDS awareness for the community.

•Include a discussion of the impact of HIV/AIDS at youth group meetings.

Additional information on World AIDS Day 2004 may be obtained/row the following websites:

United Nations Program on HIV/AIDS www.unaids.org

AVERT International AIDS Charity www.avert.org

You can receive more program suggestions and further assistance by contacting:

The Second District Religious, Educational and Charitable Development Projects, Inc. (2nd District RED. Inc.)
1134 Eleventh Street, NW 3rd Floor Suite
Washington, DC 20001 Telephone: (202)842-3788

Pilgrim Community Outreach Corporation Health and Wholeness Ministries 1648 Rosedale Street, NE Washington, DC 20002 Telephone: (202) 388-9100 Fax: (202)388-9103

SUPPLEMENTAL HIV/AIDS INFORMATION

The Second District HIV/AIDS Awareness Action Packet includes recent HIV/AIDS statistics and other information organized according to the geographical areas of the Annual Conferences. The data is provided on the right side of this packet.

Categories of Data

- HIV/AIDS Among African Americans
- General HIV/AIDS Information
- Maryland
- District of Columbia
- Virginia
- North Carolina

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